NHS
North East Essex
Clinical Commissioning Group

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30th September 2015

Dear Colleagues

North East Essex Clinical Commissioning Group Commissioning Intentions 2016-17

This letter sets out NHS North East Essex Clinical Commissioning Group's (NEE CCG) commissioning intentions for the contract year 1st April 2016 to 31st March 2017 in line with its agreed priorities.

In line with the NHS Standard Contract, which requires six months' notification for any potential changes to services and counting and coding charging proposals, these intentions will support the 2016-17 contract negotiations. These commissioning intentions should therefore be considered the CCG's formal notice letter. The technical changes for 2016/17 can be found in the specific contract and finance intentions in appendix A.

As per last year's intentions, we have set out our commissioning intentions for 2016-17 within the context of the North East Essex 5 year Strategic Plan 2014-19 (available at www.neessexccg.nhs.uk), so that providers can clearly see the direction of travel. During 2015/16 the CCG undertook the first steps to transform its community services in line with this strategic plan and secured the provider for its "Care Closer to Home" suite of services. 2016/17 will continue that transformation journey as the Care Closer to Home contract commences on 1st April 2016 and the CCG's urgent care transformation is also expected to be secured during this financial year, further details of which are set out within this document as part of the CCG's strategic commissioning intentions. These plans will reinforce the CCG's vision to deliver its QIPP objectives for 2016/17 and beyond.

NHS North East Essex CCG is currently facing a period of unprecedented financial challenge and was placed in Financial Recovery during 2015-16. On this basis the CCG's Commissioning Intentions are very much focused on maintaining quality but also delivering financial recovery to create a sustainable position for the future.

The CCG's financial strategy is articulated throughout its commissioning intentions and underpins its desire to transforms services so they are financial sustainable.

We ask that all providers strive to work with us on the delivery of our recovery plan. It should be recognised that the current financial situation in North East Essex is not restricted to the CCG system and in order for the health system to succeed we need to work together to deliver the changes necessary to deliver the best possible outcomes within a constrained financial envelope.

2016/17 will be a challenging year for health and social care partners and the CCG remains committed to working with its partners to ensure that the services it commissions represent high quality and value for money and support the delivery of improved health and well-being for the North East Essex population.

1. Introduction

This document describes NHS North East Essex CCG's commissioning intentions for 2016/17. Our commissioning intentions are the product of on-going engagement with our clinical community and stakeholders and represent our current planning and preparation for 2016/17. This document is designed to enable providers to plan for the CCG's proposed commissioning changes by engaging with them ahead of the planning round. This document also reflects the CCG's priorities and commitment set out within its five year Operational Plan.

2. NHS North East Essex CCG- About Us

NHS North East Essex CCG was established in Aril 2013. The CCG is made up of 40 member practices, with a weighted registered population of around 350,000. The CCG boundaries are largely co-terminus with the boundaries of Colchester Borough Council and Tendring District Council and include some of the most deprived wards in England.

NEE CCG is responsible for commissioning all relevant health services to meet the needs of its population. NEE CCG is the lead commissioner for Colchester Hospital University Trust (CHUFT), Anglian Community Enterprise (ACE), North Essex Partnership Foundation Trust (NEPFT and, Ramsay Health Care UK (the Oaks) and is also a collaborating commissioner for a number of other out of area contracts. The CCG also commissions a number of other services from local providers including hospices and the voluntary sector.

The CCG also has a statutory responsibility to support NHS England in providing assurances around quality of primary care provision across North East Essex. The CCG will be continuing to work with NHS England throughout 2016-17 on the development of co-commissioning plans as these progress.

3. Our Strategic Objectives and Principles

3.1 Strategic Objectives

NHS NEE CCG has a number of strategic objectives which will underpin all commissioning directions and decisions within the organisation;

- **Holistic Approach -** Achieve our vision through an inclusive, holistic approach to patient and service user- centred commissioning, embedding personalisation of care through integrated health and social care services.
- **Quality and Safety -** To transform care and drive continuous improvement in quality and safety. Achieve the best possible outcomes from our service users through high quality care
- **Best use of resources –** To use commissioning resources effectively and responsibly. To develop our organisation, teams and individual staff to be trusted, competent, well trained, talented, enthusiastic and dedicated.
- **Priority Health Goals -** To tackle the biggest health challenges in North East Essex reducing health inequalities

3.2 Strategic Principles

The following high-level strategic principles will inform all commissioning and contracting dialogues:

- To ensure the continuous improvement of quality and service provision for the patients of North East Essex.
- To achieve the whole-system financial viability, all organisations will be required to deliver their required part of the service transformation including both disinvestments and reinvestments to improve quality and effectiveness. This means that the financial viability of providers is an important consideration with our commissioning intentions.

- Where practical all investment, disinvestment or change proposals will be preceded by clinical and patient engagement.
- Focus will be given to securing added value in all current and prospective services within existing resource constraints. Existing services must be able to demonstrate value for money.
- Only activity that has been commissioned by commissioners will be paid for and commissioners will not fund the consequences of changes that have not been agreed.
- We will measure our successes and the achievement of our aims by the delivery of our transformation projects and the inclusion of key terms within our contracts for 2016-17.

4. The challenge for the North East Essex Health Economy

4.1 Financial Recovery

NHS North East Essex was formally placed in Financial Recovery in 2015-16. In order to achieve turnaround and deliver the CCG's vision and QIPP challenge the CCG has embedded a programme management approach and governance structure. The CCG has established four Programme Boards reporting to the Financial Recovery Group, which are supported by the PMO. The PMO is continuing to develop process improvements to enhance monitoring and delivery of projects and ensure financial sustainability in the future. This will ensure robust monitoring and support the CCG's financial recovery in line with its financial plan agreed with NHS England.

The CCG has identified a number of QIPP schemes for 2016/17 that will contribute towards its financial recovery and these consist of short, medium and longer terms plans. These are set out within these intentions below.

5. Our proposed approach

5.1 Key Priorities and Programmes for 2016-17

5.1.1 New models of care

Care around the Person Programme

- **Care Closer to Home (CC2H)**

The CCG awarded its Care Closer to Home contract during 2015/16, with a planned service commencement date of 1st April 2016. The CCG will work with its lead provider to successfully mobilise the new services so that there is a seamless transition to the new care model.

It is expected that the new service provider will introduce its new models of care with a phased approach, with 2016/17 being year 1 of the contract. The Care Closer to Home provider will be expected to share their own commissioning plans in preparation for the start of the contract year.
The key area of transformation under the Care around the Person Programme Board is the mobilisation of Care Closer to Home in 2015/16 so that the new model of care can be implemented from April 2016 onwards. The key changes that other providers will notice are:-

- New referral route into the CC2H services via a single point
- Transfer of some planned care services from CHUFT to CC2H –see below
- Closer working between CC2H, GPs, acute, mental health, learning disabilities services, social care and voluntary services, with care navigators playing a key role in co-ordinating patient care

- The changes should reduce avoidable A&E attendances and hospital admissions by supporting people to stay independent for as long as possible and to receive the care they need in the home or community

Planned Care
The CCG also has plans to review and redesign a number of planned care pathways throughout 2016/17, building on the foundations of the reviews started in 2015/16. These will include: -

- Transfer of planned care pathways (whole or part) from acute to community as part of the CC2H procurement - cardiology, ophthalmology, urology, therapies, pain management, MSK and podiatry
- Dermatology – the preferred option is to work with Colchester Hospital to develop a community-based dermatology service including telederm triage
- Neurology- the CCG is working with CHUFT to review the current service model to increase the use of nurses to support patient care and reduce the need for unnecessary face to face follow-up appointments
- The CCG will work with its partners to explore the greater use of technology to enable patients to self-care more confidently and provide the link between the patient and healthcare providers.

Urgent Care Centre Transformation Programme

The Vision for Urgent Care

The intended outcomes of the urgent care system is that it is able to meet the needs for the North East Essex population within the resources available, whilst delivering improved quality and patient experience. The health and social care system needs to work closely together to achieve the CCG's vision of an integrated urgent care system with the following key strategic objectives:

- Consistent, high quality treatment and care whatever time of day or wherever a patient presents, whether this be at an acute setting, the community or at home.
- Patients will be managed out of hospital wherever possible, with safe thresholds set and consistently applied
- Every consultation will have relevant patient data accessible to the clinician to enable safe advice and treatment
- All partners will recognise their role and will participate in the management of the urgent care system, with plans in place to provide capacity during surges in demand

The proposal for 2016/17 is to develop an urgent care centre model, based on best practice and in consideration to local pressures within the urgent care system recognising that the current model is unsustainable going forward.

An Urgent Care Centre (UCC) would support the approach to provide integrated care with simple access points and it would ensure people were seen in the most effective and efficient way to reduce demand on those key services.

As a principle, as part of the urgent care review the CCG will evaluate the quality and cost effectiveness of the models of care introduced by the provider within the Emergency Care Department at Colchester Hospital, including but not limited to the Clinical Decision Unit (CDU) and, Medical Decision Unit (MDU). The CCG will not commit to funding during 2016-17 and beyond, any models of care that do not add clinical value or support the CCG's financial recovery plans.

Scope

The current view as to what will be aligned to the UCC programme scope is the following;

- A&E activity – particularly minor's activity.
- Walk in Centre
- Minor Injury Units (both Clacton and Harwich)
- East of England Ambulance Service (EEAST) activity – see and treat (could this be seen at an UCC rather than result in an ambulance dispatch)

111 and out of hours

Due to the procurement timescales required with 111 and the close alignment this has with the OOH service (43% 111 dispositions fall in to OOH service) it is proposed that this is commissioned on a North Essex basis. We anticipate that the UCC model will also integrate with the newly established pathways set up within the Emergency Department and the Emergency Assessment Unit (EAU);

Current ED & EAU Pathways

We will explore how the UCC model may link with the following existing pathways as part of the options appraisal to ensure we achieve seamless patient flow;

- Clinical Decision Unit
- Medical Day Unit (for ambulatory patients)
- Frail & Elderly Unit
- Surgical Assessment Unit

Proposed approach

Three separate options appraisals to be completed – these will be based on;

- The delivery options – scope and services included in the Urgent Care Centre model.
- The location of the Urgent Care Centre
- The implementation method to be utilised.

In order to support these, the CCG will undertake wider market engagement to understand the provider desire to be involved in the delivery of the preferred model and the appetite of suppliers.

Timescales:

The CCG will be aiming for earliest mobilisation of the UCC by October 2016, below is the indicative timetable for project approval process and service commencement:

Operational Executive Committee (OEC) approval on recommended delivery options (scope and location)	29/10/15
OEC approval on recommended sourcing option	29/10/15
Full Business Case CCG Board Approval	24/11/2015
Transformation & Delivery Committee Approval of specification & Outcomes framework	05/01/2016
Finalise Commercial Model	21/12/2015

Contract Start Date	01/10/2016

6. QIPP

As part of the CCG's Financial Recovery Plan it has a number of recurrent QIPP schemes for 2015-16 that are expected to have a financial and activity impact in 2016/17. This is in addition to the new schemes prioritised and agreed for progression that may have a later start date and impact in-year in 2016/17.

The following table provide an oversight on the QIPP schemes currently identified schemes that will have an expected impact on the health system. The additional information that underpins these schemes, including the specific expected impacts will be shared with providers as part of the contract negotiations when further modelling work has been undertaken.

Annual Schemes	**Programme Board**
UC Strategy for CHUFT (Including admissions avoidance , care homes development)	UC
Data validation and contract challenges	CII
Prescribing and medicines management	CAP
Clinical Audits	CII
New Schemes	
Care Closer to Home	CAP
Non Emergency PTS re-procurement	CAP
Ophthalmology in the community	CAP
Review of contracts	CII
Review of MH contracts	MH
Learning Disability Procurement/ Improve outcomes for people with LD	MH
NEP bed management programme	MH
Integrated services for Dementia	MH
Integrated MH and Social care services	MH
CHC overhead TUPE savings - ACE	CHC
Domiciliary fast-track - FYE of 15/16 scheme (move palliative activity out of acute)	CHC
FY impact of 15/16 schemes	
Service Restriction - Vasectomies	CAP
Service Restriction - Female sterilisation	CAP
Service Restriction - IVF	CAP
Carpal Tunnel services pathway review	CAP
Paediatric urgent care - pathway review (PYE)	CAP
Neurology - pathway review	CAP
Urology - pathway review	CAP
IBS /IBD pathway review	CAP
CPP	CAP
Dermatology pathway review	CAP

GP referral and outpatient management	CII
Staff cost saving - FYE of 15/16 scheme	CHC
Pipeline ideas/potential schemes	
Enabling schemes - Commissioning for Value/ JSNA/Clinical Research Benchmarking schemes	CAP
Estates savings	CII
Renal Services/Home Dialysis	CAP
Pathway reviews and redesign	CAP
Review of FUR spend	CAP
Individual placements capping	MH
Paediatric Urgent Care Review - extension of Paediatric urgent care work	C&M
CAHMS procurement	C&M
IAPT contract	C&M
Cheviots palliative bed review	CHC
Hand on my Health and Self- care schemes - prevention	CAP
Service restriction and rationalisation	CAP
Integrated commissioning - joint working with community/voluntary/social care etc.	CAP
Review of Grants	CAP
MH services in the community - adoption of Newham Model	MH
Paediatric Vision Training	CAP

Key:
CAP- Care around the Person
CHC- continuing Healthcare
CII- Commissioning Intelligence and Innovation
C&M- Children & Maternity
MH- Mental Health

In addition the CCG wishes to signal its intention to its providers that following a clinical and prioritisation review of its commissioned services the CCG will during the remainder of 2015-16 and throughout 2016-17 potentially be considering further changes to its commissioned services, where it cannot be demonstrated that services are providing quality of care and offer value for money. This may include but not limited to, introducing revised thresholds for accessing service, changing pathways and care settings.

The current areas the CCG has identified for review are as follows:-

Speciality/ pathway area	Potential change in service
Obstetrics and Paediatrics	Review of Paediatric Clinical Immunology and allergy service
Urology	The CCG will review and agree changes to pathways including:- • Procedures appropriate for a community setting • Reduction in f-ups/ increase telephone f-ups

	• Primary care-led shared care model for PSA monitoring
Respiratory	The CCG will look at recovering: - • Savings from excess cost from 4hr home oxygen • Reducing the asthma prescribing costs for inhaled corticosteroids
Gastroenterology	The CCG will undertake the following service review to develop and improve:- • Pathway development • Integrated working across secondary and Primary Care • Referral Process • Care planning and Patient Management • Patient experience/ Engagement • Utilisation of care • Staff engagement and involvement • Outcome Development • Patient Education
Geriatric Medicine	The CCG will explore the potential for further changes to the ambulatory care pathways to improve the quality of care and greater efficiencies
Plastic Surgery	The CCG intends to introduce the following changes to the Plastic Surgery pathway: - • Manage referrals through use of Telederm and engage with Trusts to ensure inappropriate referrals are rejected and those without Telederm, where the pathway has not been followed (where appropriate, are returned to the referring clinician) • Explore the future Opportunity to scope and pursue community service at reduced tariff price
Cardiology	The CCG will: - • Consider the potential decommissioning of direct access tests at CHUFT • Review the management of Atrial Fibrillation in primary care • Review and improve the diagnosis and management of Angina in primary care • Review the Heart Failure service with the view to developing an integrated one stop service

7. Other proposed changes to clinical pathways, not including QIPP schemes

The CCG, whilst focussing on sustaining quality and delivering financial recovery and QIPP will also look at the review and redesign of its commissioned services to identify any further service improvements that can be achieved through changes to service pathways. These include the following areas/ proposed schemes: -

Specific Service Priorities/ Changes 2016/17

What	Description	Programme Board Area	Timescale
Carpal Tunnel Services	Following receipt of feedback from the market in response to a "Request for Information", the CCG will be going to procurement, with intended contract from 1st April 2016.	Care Around the Person	2015-16- 2016-17
GP Out of Hours and 111 service	We will form part of the North Essex procurement of an integrated 111 and OOHs service for North Essex	Urgent Care	2015-16- 2016-17 1st April 2017 go-live (tbc)
Non-emergency Patient Transport	We will implement the Non-emergency Patient Transport Service for NE Essex patients, from 1st April 2016, to encompass various current contracts into a single contract with a lead provider.	Care Around the Person	1st April 2016
	The CCG will reserve the right to reclaim from any Provider the cost of any aborted non-emergency patient transport journeys where the abort has been the fault of the Provider e.g. patient not ready at designated/booked time or journey no longer required by Provider but no contact made with transport provider to cancel journey	Care around the Person	2016/17
Personal Health Budgets (PHB)	We will ensure the roll out of PHB for	Mental Health	2016-17

What	Description	Programme Board Area	Timescale
	mental Health		
	We will ensure the roll out of PHBs for Continuing Health Care eligible patients	End of Life	2016-17
	We will ensure roll out of PHBs for long term conditions	Care Around the Person	2016-17
Improving assessment of continuing healthcare patients	We will require full participation in CHC DSTs by provider organisations	Care Around the Person End of Life Urgent Care Mental Health	2016-17
Maternity service improvements	We will include a maternity safety thermometer in Colchester Hospital University NHS FT and 121 Midwifes agreements, as a contractual requirement	Children & Maternity	2016-17
	We will require a 2% reduction to C-section rates in secondary care, where clinically indicated as appropriate	Children & Maternity	2016-17
Improving reporting of children's' services	We will require the inclusion of a specification and reporting requirements for SEN(D) with applicable providers.	Children & Maternity	2016-17
	Development of paediatric urgent care dashboard including adherence to RCPCH standards	Children & Maternity	2016-17
Children's services	Development of service specification for Children's Assessment Unit	Children & Maternity	Full benefit seen in 2016-17
	We will scope and develop a new ASD model for North East Essex	Children & Maternity	2016-17

What	Description	Programme Board Area	Timescale
	Development of DMO role	Children & Maternity	2016-17
Ophthalmology	We will decommission Paediatric Vision Training from a secondary care setting	Care Around the Person	2016-17
	We will consider the potential movement of clinically appropriate glaucoma follow up activity and other clinically appropriate services from secondary care to the community	Care around the Person	2016/17
Contract reporting requirements	We will request Long Stay reports for inpatients over 28 days from all providers as a contractual requirement	Commissioning Intelligence and Innovation	From 1st April 2016
	We will require patient's BMI and smoking status to be included as part of GP referrals to secondary care and recorded and reportable by providers	Care around the Person	2016/17
Pre-assessment process	We will work with providers to consider more innovative ways of undertaking pre-assessments checks to improve the patient experience	Care around the Person	2016/17
Safeguarding	We will develop key performance measures with providers in relation to PREVENT training for staff	Quality Committee	1st April 2016

What	Description	Programme Board Area	Timescale
Termination of Pregnancy	We will scope and develop a new Termination of Pregnancy model for North East Essex	Care around the Person	2015/16 - 2016/17

8. North East Essex CCG Policy changes

- **Clinical Priority Policy**

NHS North East Essex CCG will only contract with Providers that abide by our policies and protocols. These include, but are not limited to, the Clinical Priorities Policy and access criteria including, prior approval thresholds and pathways for BMI and Smoking as determined by the CCG. Referrals should clearly specify when patients meet the criteria for referral patients should only be treated if they meet the CCG's criteria for treatment.

The Clinical Priorities Policy is the CCG's corporate policy which outlines its commissioning approach for treatments and interventions which are considered low clinical priority or have limited evidence to support clinical effectiveness in terms of outcomes.

The CCG launched a revised Clinical Priorities Policy in August 2015, which was issued to providers with an expected implementation date of September 2015. This policy is a key document that is reviewed at least annually to ensure that it reflects the national and local evidence base for commissioning priority. It is expected that a further iteration of the policy will therefore be launched in 2016-17.

NHS North East Essex CCG is currently considering the opportunities for greater collaborative working with other CCG commissioners on the review and development of such policies to enable a more consistent approach to commissioning across North Essex.

9. Integrated working with Essex County Council

As we move beyond the process of agreeing planning documents and the Better Care Fund (BCF) we need to accelerate integration and action opportunities as they arise.

The CCG and ECC will continue developing, implementing and leading an integrated health and care system that empowers patients, provides more coordinated, proactive and responsive care. Its primary objective is to ensure that the whole health and care economy operates in an efficient and consistent manner as outlined in the NE Essex Five Year strategy for health and social care. Additionally there is a need that the BCF and Care Act 2014 implications are addressed and that there are adequate and clear checks and controls throughout to ensure key milestones are delivered within these programmes.

ECC will be an Associate to the Care Closer to Home contract and this signals the CCG's determination to work collaboratively with the whole health and social care market and to ensure that the enablers are in place (e.g. IT, Information Governance, Estates) to support the outcomes agreed for integration of health and care in north east Essex.

10. Strategic commissioning and the CCG's five year plan

The strategic direction of the CCG is set out in the NE Essex Strategic Plan 2014-19 as referenced on p1 of this document. The Strategic Plan aligns closely with the Five Year Forward View and emphasises the following:-

- The importance of prevention and self- care
- Empowering service users
- Building on existing community resources including the key role of the voluntary sector
- Harnessing the power of technology
- Developing new models of care and dissolving the traditional barriers between primary, community and acute services
- Integrated care based on the needs of the whole person – mental, physical and social care needs

The CCG will work with all partners including patients, carers and the public to shift services to the community wherever possible, improving patient experience, making best use of resources and freeing up acute hospitals to deliver acute care.

11. Principles of joint working with our providers

The CCG will build on the partnership working with its key stakeholders, including our providers where this will benefit patient care and deliver efficiencies across the North East Essex healthcare system.

The CCG recognises the benefits of successful joint working, with mutual trust and shared responsibilities and respect for each other's priorities and differences. The CCG therefore reiterates its agreed list of principles to facilitate collaborative working and will expect all providers to commit to and own the following principles:

- Recognise and accept the need for joint working, given our mutually shared objectives and our need to build sustainability across the economy of North East Essex.
- Develop and maintain trust by respecting our individual roles and responsibilities.
- Develop and define clarity of purpose while learning from each other to help build and maintain mutually strong reputations.
- Ensure the patient is at the centre of all decision making, and that service developments are driven by the needs of the local population.
- Maintain openness, honesty, timeliness and transparency in communication.
- Ensure a commitment to deliver high quality outcomes.
- Ensure a "no surprise" culture by committing to early discussion of emerging issues.
- Ensure commitment to deliver to agreed timescales, and respond to reasonable requests for information and cooperation.

12. Working with the Voluntary Sector

The voluntary services in Colchester and Tendring play a key role in supporting people to stay fit, healthy and engaged with their local community. Voluntary services have a wealth of knowledge about local community groups and can therefore support commissioners and Providers.

North East Essex CCG works closely with the voluntary sector and is a signatory to both the Essex Voluntary and Community Sector (VCS) Framework and Essex Compact. The CCG will be developing plans with its partners on how the wider system can contribute and support patient outcomes through utilising the sector more effectively. Our commitment to these principles and outcomes need to be expressed not only in the work we do but of our providers too. For example:

- Ensuring that the Voluntary Sector participate on a level playing field with the private and public sector
- Aligning commissioning cycles with other public bodies to improve joint commissioning opportunities where possible
- Encouraging the sector to come together, including developing consortia and supply chains, with other providers

- Working with the VCS to build capacity and identify areas for market development
- Developing Services with the voluntary sector in mind. This may include outlining expectations or setting outcomes on providers to utilise the sector as part of their delivery models
- Maximise the use of volunteers within commissioned services. Providers will recognise the added value and benefit they bring to a service alongside the support they will need to fulfil their roles
- Building networks and relationships with Voluntary Services who can add knowledge and expertise

13. Quality

Quality of care remains at the heart of the commissioning decisions made by NEE CCG. Whilst some difficult decisions have been made in 2015-16 and can be expected in 2016-17 the CCG will always consider the impact on its patients and ensure that responsible decisions are made.

The CCG will uphold its statutory responsibilities under the Health and Social Care Act 2012 to ensure continuous quality improvement in the services it commissions. NEE CCG will ensure that it follows and embeds in its practice and its contracts, the national guidance for improving patient care and safety when this is published, building on the foundations of change brought about by the public enquiry into Mid Staffordshire NHS Foundation Trust and the national publication of reports such as the Francis report and the Keogh Review.

NEE CCG will strive to improve the quality of care of its patients through the services it commissions and will use its contractual levers to facilitate improvement in standards of care where performance does not meet the required quality and safety standards.

The CCG will work with its providers to understand their workforce plans to provide assurances that the services they provide are sufficiently staffed with the appropriate skill mix and ratios required. The CCG will expect transparency from its providers to the CCG and the public on this issue and will expect this information to continue to be updated and published on the NHS Choices website.

During the contractual year 2016-17, NEECCG will continue to focus on the incorporation of outcome based measurements into our contracts based on the NHS Outcomes Framework and to align with the commissioning of Care Closer to Home services.

14. National, Regional and Local Drivers

We will ensure that our commissioning strategies remain aligned with the following national, regional and local initiatives including:-

- NHS Outcomes Framework and CCG Indicator Set
- Essex Joint Strategic Needs Assessment
- Essex Health and Wellbeing Strategy
- NHS Constitution
- NHS Mandate
- NHS North East Essex CCG Five Year Strategic Plan
- NEE CCG Constitution
- Francis Report
- Keogh Review
- Berwick Report
- Winterbourne Report

- Hard Truths
- NHS Seven Days a Week Forum Clinical Standards

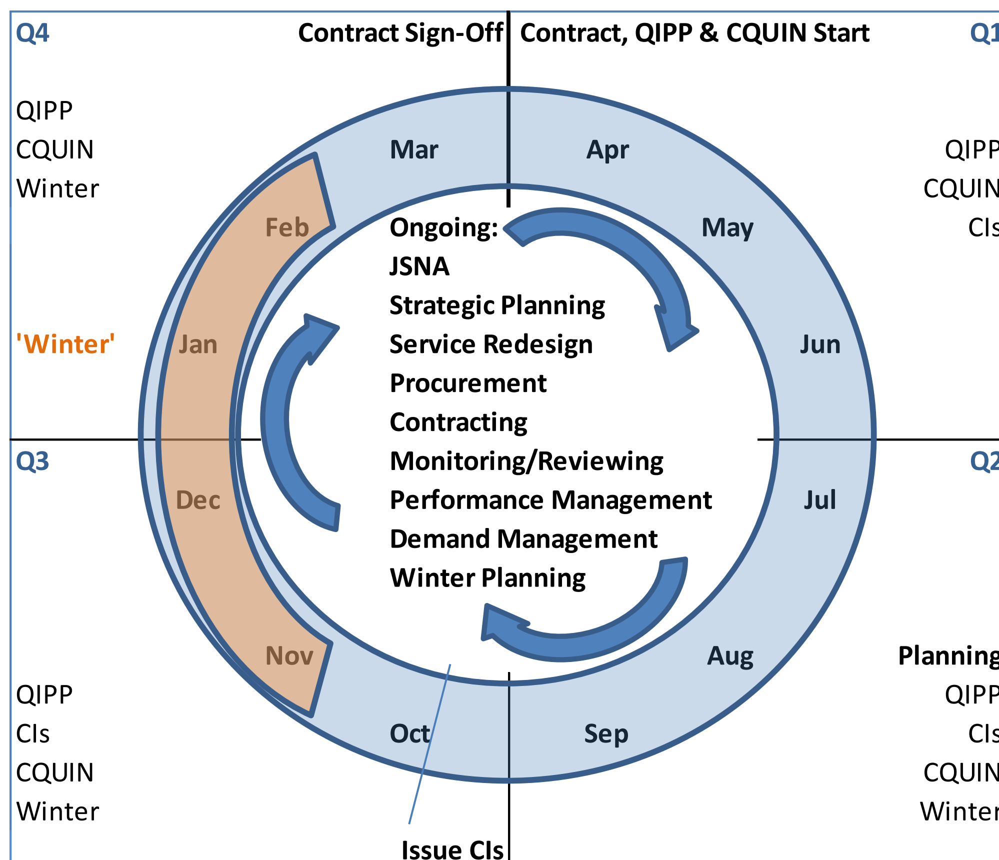
15. Commissioning Cycle

NEE CCG will continue to commission its services in accordance with the annual commissioning cycle as per figure 1 below.

There will be rolling commissioning intentions and, as and when appropriate, our providers and partners will be notified of these and the evidence base and rationale behind these intentions.

Changes to activity plans will continue to be managed through the monthly contract meetings.

Figure 1



I hope you find our Commissioning Intentions document helpful in clearly setting out our direction for 2016-17, in line with the current known local and national priorities. Please be aware that the intentions within this letter may therefore be subject to change depending on publication of further guidance at either a national, regional or local level.

These commissioning intentions will be distributed to providers, primary care, patient participation groups, local health forums, associate commissioners and all known stakeholders for views and comments.

Yours sincerely

S. Hepplewhite

Samantha Hepplewhite
Acting Chief Officer
North East Essex Clinical Commissioning Group

APPENDIX A

Contracting Intentions

1. Collaborative Commissioning and Contracting

1.1 NEE CCG intends to maximise the efficiencies for contracting by continuing to collaborate with other commissioners where appropriate and in line with published guidance.

1.2 To support integration of services across the North East Essex health economy the contracting team continue to explore how the Standard NHS contract can be used differently across multiple providers.

1.3 Where NEE CCG takes a lead commissioner role on contracts, it will liaise with collaborating commissioners and coordinate the making of commissioning and contracting decisions.

1.4 Whilst NEE CCG may lead on contracts on behalf of other collaborating commissioners it will only be responsible for payment of activity relating to the population of NEE (including the resident population in NEE for urgent care). Collaborating commissioners will be responsible for the costs of activity for their own population for all services operating on a cost & volume basis. Where block contracts remain in 2016/17 estimation may be required to allocate the service cost to respective commissioners.

1.5 Where NEE CCG takes a lead commissioner role on contracts, and provides defined services on behalf of collaborating commissioners, it may require a contribution in respect of the staffing and other costs of supporting the contract.

2. Succession Planning

2.1. On termination or expiry of a contract or service the parties are contractually obliged to agree a succession plan for the transition of the service or contract to a new provider (or to cease the service if not re-procured).

2.2. (GC 18.4.2) ‘At the reasonable cost and reasonable request of the Co-ordinating Commissioner the Provider is required to promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the terminated Services by a successor provider’.

2.3. A detailed template succession plan covering the headings below will be developed. The plan with identified timescales and resource will be agreed with the outgoing provider within one month of giving notice on services. The succession plan will be managed in tandem with the successor provider’s mobilisation plan by the project team.

Contractual Requirements:		Responsible Party
1.	Details of the affected service	Joint
2.	Service line costs for the identified service	Joint
3.	Details of service users and/or user groups affected	Joint
4.	The date on which a successor provider will take responsibility	Commissioner
5.	Risks to service users and employees	Joint
5a.	Identify and minimise inconvenience to service users	Joint
6.	Staffing	Provider
7.	TUPE	Provider
8.	Data register/storage/transfer/integrity	Joint
9.	Service User health records	Joint (provider led)
9a.	Provider plans for storage and destruction	Provider
9b.	Transfer to commissioner or 3rd party	Provider
10.	Documentation/ownership	Provider
10a	Manuals/policies	Provider
10b.	Processes procedures	Provider
10c.	Training manuals	Provider
10d.	Knowledge transfer	Joint
11.	Related third party contract/agreements	Provider
12.	Stop referrals into service	Commissioner
13.	Stop accepting referrals	Provider
14.	Stop treatment or transfer/discharge to new service	Provider
15.	Implications of CRS or Essential services	Joint
16.	Implications of any ‘Exit arrangements’ Sch 2 part 1	Commissioner
17.	Payment for services	Commissioner

18.	Review any remedial action plans/sums withheld	Commissioner
19.	Review any Information breaches and sums withheld	Commissioner
20.	Continued Indemnity for 21 years	Provider
21.	Recover costs of re-provision (Termination provider fault)	Commissioner
22.	Confidential Information of the Parties (survives 5 years)	Joint
23.	Intellectual property/transfer	Joint
Other Considerations:		
	Equipment stock-take/asset register/ownership/transfer	Provider
	Estates register/notice/retention/ transfer/vacancy dates	Provider
	ICT/systems/equipment/transfer	Provider
	Communication plans	Joint
	Identify resource for succession plan completion	Commissioner
Costs to Incumbent Provider:		Provider
	Non-recurrent costs:	
	Redundancy	
	Exit of leases – premises/equipment/software	
	Costs of staff transfer	
	Recurrent Unavoidable Costs:	
	Costs absorbed by service lines e.g. under used estate	
	Costs of operational interface with new provider	

Incumbent Provider business continuity/risk management for 6 months post transfer.

3. Commissioning Support

3.1. Where NEE CCG is an associate to a wider collaborative contract it may choose to source support from a Commissioning Support Unit (CSU) in managing these contracts, remaining vigilant that the Health and Social Care act makes clear that even within collaborative agreements CCGs will always remain accountable for meeting their statutory duties.

3.2. Where support is sourced from a CSU, in certain instances the CCG may ask such CSU representatives to represent it in discussions and negotiations. Where this happens the CCG will have clear governance arrangements in place in respect of the delegation of such responsibilities.

4. Choice

4.1 NHS NEE CCG will uphold the right to choice under the NHS Constitution and will ensure patients have the right to make choices about their NHS care and are provided with the information to support these choices.

4.2 The CCG will continue to champion patients' rights to make choices about the care they receive by supporting the provision of reasonable information to help support that choice.

5. 18 Weeks

5.1. All providers will be expected to comply with national waiting times, including 18 weeks for consultant led services, in accordance with national and locally agreed guidance including but not limited to contractual requirements and the NHS Constitution.

5.2. NHS North East Essex CCG will work with all providers to ensure that performance standards are achieved and sustained.

6. Cancer

6.1. Providers will be expected to meet all national cancer waiting times and deliver the national and local priorities for the North East Essex population as identified by the Strategic Clinical Network and shall adhere to all implementation timescales as agreed with the commissioner. The CCG will promote patient's rights under the NHS Constitution and shall expect the principles and rights under the Constitution to be recognised and upheld by all providers to ensure fair and equitable access and treatment for patients.

6.2. The CCG will commission those cancer services, for which it is responsible, in accordance with the assessment of its population need based on best practice, evidence based guidance and quality of care and outcomes. NHS NEE CCG will work with stakeholders including NHS England and service user groups to help deliver improved outcomes for patients by improving early diagnosis and supporting people to live well beyond cancer

7. Networks

7.1. The CCG will take guidance from the East of England Strategic Clinical Networks in the commissioning of its services to ensure that they reflect best clinical practice and patient care:

7.2. Providers will be required to actively participate in relevant networks and adhere to agreed network guidelines, policies and protocols when released.

8. Patient, Public, Service User and Carer Engagement

8.1. Providers will be expected to demonstrate regular and relevant engagement with the public, patients, service users and carers. Providers will be expected to supply an engagement plan/strategy and progress against the same will be monitored.

8.2. Providers must ensure that there are inclusive of all patients views and should demonstrate equity of access for patients who may find it more difficult to access services, including those where English is not their first language or patients with a learning disability.

9. Emergency Preparedness, Resilience and Response

9.1. All commissioned services will be expected to fulfil the requirements of the following providing assurance as required;

- 9.1..1. NHS Standard Contract, Service Conditions SC30 Emergencies and Incidents
- 9.1..2. Civil Contingencies Act 2004
- 9.1..3. Care Quality Commission Essential Standards of Quality and Safety

9.2. Full use of the East of England Capacity and Activity Management System (CAMS) will be included within Acute and Community Provider Contracts including;

- 9.2..1. Regular (at least annual) update of declared bed stock data to the East of England CAMS capacity team.
- 9.2..2. Daily update of live CAMS data in line with published update schedules, currently;
  - 9.2..2.1. Emergency Department, every 2 Hours 24/7/365
  - 9.2..2.2. Acute Bed Status, every 4 hours 0600-2200
  - 9.2..2.3. Critical Care, minimum 3 times a day
  - 9.2..2.4. Community Beds, minimum 2 times a day

10. General principles

NEE CCG will:

10.1 Annually review and refresh all contracts.

10.2 Review and maintain its contestability plan as a live document to plan priority areas for future contracting and procurement of these services. The CCG will be required to adhere to competition rules and procurement regulations, and all opportunities will be advertised on Contracts Finder portal and OJEU as appropriate.

10.3 Use the NHS Standard Contracts as the basis for contracting all Health Services where appropriate and in line with national guidance, with the exception of GP Out of Hours services which stipulate the use of APMS contracts.

10.4 Review and negotiate robust outcome based quality requirements in line with national and local priorities and will use contract management tools to set appropriate contractual and/or financial consequences for performance failures.

10.5 Continue work to develop a system to measure outcomes at service and patient level which will initiate the process to achieve our long term objectives of transitioning to commissioning (and paying for) solely on achievement of outcomes.

10.6 Fully use all necessary contractual levers available during 2016/17 to ensure performance remains in line with expectations and agreed standards.

10.7 Ensure that the contract is consistent with the principles of the NHS Constitution and expects Providers to comply with these requirements and provide reports on compliance as locally agreed.

10.8 Expect Providers to achieve all national, regional and local waiting time standards and will seek to include provisions regarding redress where these standards are not achieved.

10.9 Agree core quality & performance indicators and reporting mechanisms for 2016/17 in advance of contract sign off.

10.10 Continue work on development or review of Service Specifications for all contracts in line with agreed work-programmes and services redesigned by QIPP projects.

10.11 Work with Providers to agree service specific metrics in line with a pre-determined work programme.

10.12 Wish to finalise appropriate CQUIN schemes prior to the start of the new financial year. Ideas for new schemes are sought from Providers for consideration and will form part of negotiations. We are particularly keen to develop economy-wide CQUINs with multiple Providers.

10.13 Expect all providers to comply with Network agreed clinical pathways and work in accordance with the priorities and intentions of the Networks for 2016-17, adopting any best practice and service specifications agreed. NEE CCG will review compliance with Networks and conduct independent reviews of services where necessary.

10.14 Review designation of services as CRS (Commissioner Requested Service) in line with national guidance and local contestability plans.

11 Financial principles

NEE CCG will:

11.1 Not pay for any service developments and / or associated cost pressures unless approved in advance during the contracting round, and where appropriate following requisite contractual notice of change.

11.2 Not pay for services provided to patients who are not registered with a North East Essex GP Practice, or chargeable under recognised national guidance, at the time of their treatment.

11.3 Expect all block contract services to be moved to a cost & volume basis for 2016/17, unless agreed by exception that a service should remain funded on a block basis, or the contractual form is based on a predominantly block arrangement. Where this is not achieved a timetable will need to be agreed with the Provider for the disaggregation of any remaining block contracts. Failure to meet agreed timescales, and provide required supporting data may lead to non-payment for services. Where data to support a move to cost and volume is not available, the service will remain on block.

11.4 Expect all Providers to have passed back the commissioning of non-urgent patient transport services (PTS) to local CCGs. Where Providers retain PTS contracts, the CCG will not fund these through the main acute contract.

11.5 The CCG is putting in place new arrangements for PTS, commencing April 2016, with the provider taking delegated responsibility for the management of all PTS & HCTS (Healthcare Travel Scheme). Providers will therefore be required to work with the PTS provider in respect of transport arrangements and associated financial management.

11.6 Reserves the right to reclaim from the Provider the cost of any aborted non-emergency patient transport journeys where the abort has been the fault of the Provider e.g. patient not ready at designated/booked time or journey no longer required by Provider but no contact made with transport provider to cancel journey.

11.7 Expect all Providers to support the CCG, and its PTS provider, to ensure booking systems, eligibility criteria and other service requirements are followed by Provider staff in respect of all non-urgent Patient Transport Services.

11.8 Support providers to ensure appropriate transfer to social care services, and support arrangements for recovery of costs where delays occur.

11.9 In line with PbR guidance, not pay excess bed day charges for patients that are identified as social care waiters and therefore fineable to the Local Authority. Any historic local arrangements in respect of daily charges/refunds will be superseded by PbR guidance.

11.10 Work with Providers to ensure all Best Practice tariffs are implemented, and that supporting data capture and reporting systems are in place to manage the payment process. Payment of Best Practice tariffs will only be made where Providers can demonstrate delivery and provide appropriate supporting data.

11.11 Adopt all aspects of mandatory PbR tariffs, unless explicitly agreed with Providers. Where mandatory PbR tariffs do not exist the CCG will adopt non-mandatory PbR tariffs, or where these do not exist the latest available National Average Reference Costs adjusted for inflation. Where existing prices differ from the above these will be reviewed, and local tariffs may be agreed, including as part of transition to PbR tariffs.

11.12 Work in partnership to unbundle tariffs where pathways span multiple providers, and/or where QIPP initiatives or service redesign supports unbundling.

11.13 Review and refresh specific activity & finance terms agreed in existing contracts, to ensure absolute clarity on data validation, contract management rules and thresholds for contractual performance/penalties.

11.14 Not pay where counting and/or recording changes are implemented by a Provider without prior agreement from the CCG and, where appropriate notice (generally 6 months) of the financial and activity impact is not given.

11.15 Follow all national guidance on readmissions and will refresh its agreed policy and process for all re-admissions accordingly.

11.15.1 Where emergency re-admissions, within 30 days of the original discharge, occur across multiple Providers we will invoice the originating provider in line with PbR guidance, the value of the readmission charged to the CCG. This is subject to update following 2016/17 guidance.

11.15.2 Where readmissions occur within a single Provider these will be paid in line with national guidance and the agreed threshold within the contract, following the audit review. Again, this is subject to update following 2016/17 guidance and further audit.

11.16 Review the threshold agreed in current contracts for Planned Procedures not carried out (WA14Zs). However it expects that current arrangements will remain in place.

11.17 Negotiate costed activity schedules using national and regional guidance, including Payment by Results and National Outcomes Framework.

11.18 Not pay more for the same services, regardless of whether increases are brought about by technical changes such as movement from block to cost and volume, or changes to recording currencies.

11.19 Requests for contractual changes (changes to tariffs, not patient care) will require evidence based proposals, with the 6 month notice only accepted from when the proposals have been signed off.

11.20 Work with providers to review the current financial arrangements for equipment services.

11.21 Intend to commission on the same payment and contractual basis where similar services are commissioned from multiple providers.

11.22 Not pay for A&E attendances that are generated through the A&E itself or EAU; e.g. where a patient has been asked to return to A&E for reasons or treatment relating to a prior attendance.

11.23 Not accept that historic arrangements for disaggregation of PCT services are an acceptable basis for Providers to request additional funding/cost pressures. The CCG believes these legacy arrangements are no longer valid, and will not fund cost pressures emanating from renegotiation of Provider to Provider agreements for services, or renegotiation of corporate/estates charges. The CCG expects all Providers to manage any pressures within their own resources – and equally will not expect a share of any benefits

11.24 Performance manage providers who treat patients outside of Clinical Priorities Policy, and all where treatment has occurred and been charged inappropriately such activity will be zero costed.

11.25 Not accept increases (outside of the principles above) to prices for residual services, following a reduction in the level, complexity or breadth of a wider service as a result of planned service changes, changes to contractual arrangements and/or service provider.

11.26 The CCG will, primarily through its procurement process, be looking for innovative ways of managing financial elements of its contracts supporting the move towards outcome based contracts. Payment methodologies will be geared more towards performance/delivery outcomes, rather than purely activity based.

12 Information/Activity principles

NEE CCG will:

12.1 Work together with Providers in agreeing the activity Plan for 2016-17 taking into consideration the impact of QIPP projects, service reviews and other factors, such as changing referral patterns linked to Choice, demographic changes and other relevant factors.

12.2 Expect SUS to be used as the definitive data source for data and payment for all services that SUS covers. Where SUS data is not complete and/or accurate, or agreement cannot be reached on its use as the primary payment system we reserve the right to continue to request local datasets. A costed patient record level MDS, reconciled to summary reporting, will be expected for all contracts to enable analysis and validation of data and performance reporting.

12.3 Expect all providers to submit a costed patient identifiable dataset to NELCSU, who will weakly pseudonymise the dataset before sending to the CCG safe haven.

12.4 Employ standard validation processes across all contracts, and work with Providers to identify and reconcile and differences in outputs from Provider performance reports and CCG validated outputs in line with national timetables. The CCG will only pay for appropriate activity.

12.5 Not pay, unless specifically agreed in advance, for activity where the NHS number/GP Practice is not provided. To enable all contracts to be split across CCG's and practices, it is essential that all non-PbR activity and costs are attributed to practices at MDS level using the standard practice codes. In addition, we will work with Providers to attribute all non PbR expenditure to programme budgeting categories at year end where this is not identified by the HRG Grouper. This is subject to review, and where appropriate temporary alternative arrangements, where national guidance or statutory requirements prevent the flow of such data.

12.6 In line with national guidance, only pay for a single outpatient first attendance as a result of an individual referral within a single specialty. Consultant to Consultant referrals for the same referred condition will be considered as follow up attendances.

12.7 Review outpatient follow-up ratios with performance benchmarked against national, regional and local comparators. There is an expectation that Providers will work to reduce the number of follow-ups, and therefore improve ratios, by the use of telephone contacts, technology and other appropriate means wherever possible – and in conjunction with the commissioner. Where innovative approaches are proposed the CCG will look to negotiate an incentivised basis for reductions. Providers will be expected to at least maintain delivery of current contractual requirements.

12.8 Work with Providers to design and deliver a programme of clinical and coding audits, supported by benchmarking and comparative analysis, to validate and review patient pathways and coding and support the management/ monitoring of any thresholds set in contracts and in order to form baselines for future contract standards. This will include clinical audit and will require Providers to co-operate in making available appropriate clinical staff to support this.

12.9 Require providers to participate in selected National Audits and via the NHS Benchmarking Network.

12.10 As part of contract negotiations, intend to develop an indicative profiled activity plan for all services for 2016/17 and will further develop our approach to monitoring of activity against plan as part of our contract management arrangements.

12.11 Identify where CCG services are purchased from a CSU or DSCRO (Data Service for Commissioners Regional Office), and flag any changes that may be required to Provider arrangements for the transmission of datasets, and possibly the format and media of those

datasets. We will review and strengthen the exact requirements in Schedule 6 of the contract Particulars and other supporting Information schedules, and these changes will be discussed and agreed with Providers during contract negotiations.

12.12 As a result of national requirements for the externalisation of support functions, need Providers to ensure that the format of datasets received is in line with the agreed contract and are received in that consistent format throughout the year. Failure to provide data in the agreed format, without prior agreement/variation, may lead to files not being processed, and either non-payment or delay in payment.

12.13 Include financial penalties in the 2016-17 Contract for the non-provision of information. This will include the consistent and accurate use of the NHS number in all patient datasets. This is subject to review, and where appropriate temporary alternative arrangements, where national guidance or statutory requirements prevent the flow of such data.

12.14 Wish to agree a revised Data Quality Improvement Plan (DQIP) with all Providers, and reporting mechanisms to provide continued assurance that key data requirements and milestones are being fully delivered within agreed timescales. This will need to show clear links and planned progress towards the informatics requirements detailed in national guidance.

12.15 Expect that for all services the location of any contact is clearly recorded and identifiable.

12.16 Review and strive to constantly improve the quality of all activity and referral data, including the development, with Providers, of appropriate processes and quality monitoring mechanisms that make best use of existing and future technologies.

12.17 Expect all Providers to provide finance and activity performance reports and supporting local data (where not derived from SUS, as per 11.2 above), in an agreed format and frequency, to enable payment against contracts, and support validation and reconciliation against CCG reports. The CCG will work with Providers to ensure that, where possible;

12.17.1 These reports are in a format that allows automated reconciliation with CCG reports,

12.17.2 These reports can be generated from existing Provider systems/internal reporting to minimise any duplication of effort

12.18 Where providers submit performance and other data to national systems there is often a time lag (of up to one week) before commissioners can extract this data. The CCG therefore requires providers to either;

12.18.1 Supply copies, on the day of submission, of all statutory returns made to the following systems; DH UNIFY, Information Centre Omnibus and Health Protection Agency systems, or

12.18.2 Authorise, where required, CCG access to unify and/or other systems to enable viewing if Provider returns once they are submitted and authorised

This will enable CCG assurance that the returns have been completed on time, and to provide an opportunity to utilise the data in respect of our population before the returns are made public by the receiving system.

12.19 Will be placing less emphasis on activity based commissioning and will be moving towards outcome based commissioning, unless contracts specifically state otherwise

The provider Will:

12.20 Be responsible for, and expected to provide all necessary hardware, software, peripherals and licencing support their effective delivery of the contracted services

12.21 Be required to ensure appropriate N3 connectivity is available and supported in its key sites that require access to N3 system, and/or the processing and transmission of data and information requiring N3

13 Specialist Commissioning and Other Non CCG Commissioning

13.1 The CCG requires all Providers to follow national guidance in respect of coding, counting and charging - ensuring activity is correctly recorded to the appropriate commissioner code. This includes (but is not limited to); Specialist Commissioning, Dental, Military, Screening, Sexual Health & other nationally or locally identified Public Health and Local Area team services.

13.2 In respect of changes to guidance, local agreement or other variation commencing 2016/17, the CCG may request from Providers a full reconciliation of the previous year out-turn with activity/costs remapped to revised arrangements, to enable the validation and sign-off on 2016/17 plans.

13.3 Where in-year changes occur in respect of commissioning responsibility for a service, the CCG would expect all providers to support and provide relevant activity and financial data, potentially for multiple years, to enable the effective and accurate setting of contract plans. Such changes will be effected by way of a contract variation.

14 Peer Review

14.1 Providers will be expected to have in place a programme of peer review audits and to provide evidence to commissioners of both the programme and compliance with the same.

NHS
North East Essex
Clinical Commissioning Group

APPENDIX B

MEDICINES OPTIMISATION PRINCIPLES AND COMMISSIONING INTENTIONS

1. Providers and Commissioners will work together to ensure that medicines optimisation principles are embedded within contracts:
2. Drugs and Devices- There will be a review of the current medicines management section of contracts to ensure these are still in line with local policies, including reviewing the position on unlicensed drugs and clinical trials and validation processes. Providers will be expected to have in place robust processes for implementing NICE TAGs and quality standards (both drugs and other interventions).
3. Clear processes will be agreed with providers to provide horizon scanning to forecast the likely impact of new drugs or technologies in year (whether included or excluded from tariff) and license extensions to ensure that the CCG can understand the impact of any direct costs to the commissioner or any 'influence' on prescribing practices. These will include NICE TAGs and any major new technologies. The CCG's preferred model is to use the UKMi's *Prescribing Outlook - New Medicines 2015*
4. All clinical pathways will specify formulary medicines and technologies where appropriate.
5. The Provider will support commissioners to implement the Quality, Innovation, Productivity and Prevention (QIPP) programme for medicines optimisation e.g. including adherence to the Commissioner agreed prescribing formularies and guidelines, implementation of NICE TAGs and guidelines when formally commissioned and agreed and improvement of patient medication concordance.
6. All contracted providers will adhere to Commissioner Medicines Management Standards to support safe and cost-effective medicines optimisation. The Commissioner will engage with the Provider through the North East Essex Medicines Management Committee in finalising these standards, following which they will be expected to comply with the agreed standards.
7. The Provider shall participate in the North East Essex Medicines Management Committee and work co-operatively, actively and closely with the Commissioner to develop prescribing guidelines and manage the entry of new drugs into the local economy.
8. Agreed local decision making processes will be applied across the organisation and formulary decisions adhered to.
9. The clinical decision to treat outside the approved/formulary drugs list is the responsibility of the prescriber in agreement with the patient, and the cost of these drugs will not be funded by the Commissioner, unless individual arrangements are agreed. The Commissioner will monitor non-formulary prescribing and will request information to support these decisions.
10. The Provider must highlight to commissioners any major changes to treatment pathways/provision of services which may impact on primary care medicines management
11. The Provider will continue to support formulary prescribing by actively reviewing all patients admitted on non-formulary medicines and changing patients to formulary drugs where appropriate to do so and when agreed with the commissioners
12. The Provider shall work with the Commissioner to rationalise and minimise the use of specials and 'unlicensed' medicines (all of which should be formulary approved) and advise when asked the most cost-effective means of purchase.
13. The Provider shall not ask GPs to prescribe drugs and dressings which have been deemed suitable for 'hospital only' prescribing by the North East Essex Medicines Management Committee, any dressings not included in the full dressing's formulary or devices not listed in the Drug Tariff without prior approval. Where GPs are asked to prescribe such 'hospital only' drugs or dressings, the CCG will seek to recharge the cost to the Provider.

14. If a medication is initiated by the Provider the responsibility for arranging any subsequent associated testing and monitoring (monitoring is defined as receiving a result and acting on that result) lies with the initiating prescriber unless agreement has been sought from the patient's GP and the GP has agreed to take on that responsibility.
15. In-Patients
    15.1 The Provider shall not ask GPs to prescribe drugs and dressings which are included in the commissioned service and intended for treatment of in patients or in preparation for admission. Where pre-operative drugs are identified by the Provider as being necessary to facilitate treatment, we will not accept referral back or requests for primary care prescription as these are included in national tariff (unless part of an agreed pathway redesign, in which case funding will follow prescribing).
    15.2 The Provider shall support patients to manage (self-administer and order) their own medicines during their hospital stay, through the implementation of a Self-Administration Assessment and Delivery programme, which should include medication rehabilitation/re-ablement.
    15.3 The Provider will act to resolve any medication non-compliance issues identified on admission or during the patient's hospital stay.
    15.4 The Provider will work closely with commissioners and community pharmacies to maximise benefits for 'high risk patients' and newly discharged patients by referring them for Medicines Use Reviews or other Advanced Services as appropriate.
    15.5 The Provider shall work with primary care colleagues and other providers to ensure seamless transfer of pharmaceutical care between care settings.
    15.6 The Provider will risk assess patients discharged on drugs with a potential for addiction or abuse e.g. opioids and hypnotics, and clarify the pharmaceutical care plan with primary care colleagues prior to discharge.
    15.7 The Provider shall have systems in place to ensure that patients are supplied with an uninterrupted supply of medicines, dressings and/or oral nutritional supplements on discharge, and that information is provided to the patient, their GP and their carer in a timely manner.
16. Out-Patients
    16.1 The Provider shall not ask GPs to prescribe drugs and dressings which are included in the commissioned service and intended for treatment of patients attending out-patient clinics or day-care surgery.
    16.2 The Provider shall make arrangements for out-patient prescriptions to be dispensed or medication supplied promptly. The Provider will not advise patients to ask their GP to transfer their hospital out-patient prescription to an FP10 prescription. In such instances the associated costs will be recouped from Providers.
    16.3 The Provider will act to resolve any medication non-compliance issues identified and will work closely with commissioners and community pharmacies to maximise benefits for 'high risk patients' by referring them for Medicines Use Reviews as appropriate.
    16.4 The Provider will work with the Commissioner to develop and implement monitoring and audit tools to support and demonstrate prescribing within formulary and guidelines.
    16.5 The provider will work with commissioners to ensure that ongoing treatment is cost effective for the whole healthcare economy.
17. Shared and continuing care agreements
    17.1 For drugs subject to a shared or continuing care protocol, specialists shall continue prescribing until a patient-specific agreement has been put in place with the GP.
    17.2 When a shared or continuing care agreement is in place, specialists and GPs shall undertake the responsibilities outlined in the protocol.

17.3 The Provider will work with the Commissioner to review existing shared-care arrangements, supporting GPs to manage these patients, reducing the need for hospital attendance and discharging where appropriate. Support may include a rapid follow-up appointment with or advice from the consultant if necessary.

17.4 The Provider shall have systems in place to ensure that patients transferred to other care settings have an uninterrupted supply of medicines, and/or oral nutritional supplements and that information is provided to the patient, their GP and their carer in a timely manner.

17.5 The cost of medicines, dressings and pharmaceutical preparations used or provided shall be covered within the agreed tariff for the service, other than drugs excluded from tariff.

18. Provision of medications on discharge

18.1 The Provider will ensure that the patient receives the appropriate supply of medicines, dressings or nutritional substances (absolute minimum 7 days) to ensure sufficient time for the patient to see their GP and obtain any required repeat prescriptions. Longer periods of supply may be necessary in the following exceptions: chemotherapy, fertility treatment, haematology treatments and any other instances where treatments are the responsibility of the Provider.

18.2 If a medication is initiated by the Provider the responsibility for arranging any subsequent associated testing and monitoring (monitoring is defined as receiving a result and acting on that result) lies with the initiating prescriber unless agreement has been sought from the patient’s GP and the GP has agreed to take on that responsibility.

18.3 Where oxygen is needed on discharge, the Provider will ensure that the requirement is picked up during discharge planning so that there is no need for an urgent four-hour request.

18.4 Where a patient is discharged using oxygen, the Provider will work with primary care colleagues to ensure that sufficient information is given on the discharge documentation and support is available to ensure appropriate use.

19. Drugs and devices excluded from tariff

19.1 The Provider shall work closely with the commissioner, provide information relating to drug and device exclusions and facilitate changes in commissioner and payer as necessary.

19.2 Providers will follow the commissioning intentions for High Cost Drugs which are included in the contract and updated each year by the EoE Commissioning Pharmacists group. To release payment (irrespective of funder or funding stream e.g. best practice tariff) all providers must comply with local and agreed East of England drugs policies and share acquisition costs, patient level information and indications.

19.3 The Provider shall seek prior approval using the agreed prior approval pro-formas for NICE and locally commissioned drugs and devices.

19.4 The Provider will further develop and maintain systems (Blueteq) for the facilitation of approval, checking and appropriate payment of all drugs/devices excluded from tariff

19.5 All drugs and devices excluded from tariff are not normally commissioned unless specifically agreed by the Commissioner.

19.6 The Commissioner shall only pay where the drug has been used for an approved indication, relevant criteria are met and the agreed dataset provided.

19.7 For drugs and devices excluded from tariff the Commissioner will pay the agreed prices for those drugs prescribed for indications as detailed in Guidance and within agreed guidelines.

19.8 The Commissioner may undertake formal clinical audit of groups of patients and ensure that there are robust criteria in place for commencing and stopping medication.

19.9 The Provider shall provide full information, as agreed, with invoices for drugs and devices.

19.10 Invoices without the necessary information and within the agreed timeframe will not be paid.

19.11 The Commissioner shall withhold payment for anomalies or issues identified until the issue is resolved. If the time agreed for resolution is passed and issues/ anomalies remain unresolved payment will not be made. Post payment verification audit of the use of drugs outside tariffs and / or in non tariff services may be required.

19.12 The Provider shall routinely prescribe lower cost drugs where these have been proven to be clinically effective and will not prescribe drugs excluded from tariff where there is a clinically appropriate, non-excluded drug unless specifically agreed in writing.

19.13 It is the intention of Commissioners to continue to review the supply of drugs excluded from tariff with a view to ensuring that they are administered through the most appropriate route (e.g. sub cut formulations) both clinically and economically, in the interests of the patient

19.14 As biosimilar drugs become available, the Provider shall routinely prescribe biosimilars as opposed to the reference molecule. Commissioners will consider gainshare agreements to support implementation which may include e.g. joint funding or improvements in service quality.

19.15 The Provider shall operate full open book accounting and patient administration recording systems on such purchasing. The Commissioner will use its best endeavours to support the Provider in ensuring maximum efficiency in these purchasing arrangements with financial support to achieve this where necessary.

20. Commissioners wish to continue to work with the Provider to maximise advantageous drug purchasing arrangements to get best value for money for specialist drugs and consider areas where it is advantageous, both clinically and financially, for the provider to retain on-going prescribing responsibility for outpatients with appropriate reimbursement for cost of drugs and recognition of any additional administrative burden.
21. It is the intention of Commissioners to continue to review the location for delivery of regular intravenous infusions and maximise the use of homecare and community locations, including use of Community Providers, to improve the patient experience whilst ensuring continued quality and safety of the service.
22. The Provider shall use agreed home care provider companies with direct invoicing to the Commissioner when formal NHS contracts have been established (through EoE Procurement Hub and Pharmacy Category Management Group) and supported through local contracts as necessary. The Provider shall notify the Commissioner in advance of any variance or new arrangement, which should follow the best practice guidance 'Homecare Medicines "Towards a Vision for the Future" 'DH November 2011 and the 'RPS Standards for Homecare'.
23. Commissioners recognise that the Provider may wish to explore alternative methods of medication supply. The Provider must ensure that any sub-contractor meets the Commissioner Medicines management standards and Commissioners must be included in any such discussions and finally agree any sub-contractor arrangements.
24. The Provider shall ensure it has robust arrangements for the safe and secure use and handling of Controlled Drugs in line with national regulations and guidance, and will allow the Commissioner to access premises to conduct audits, inspections and investigations. Whilst recognising that the Trust has an appointed CD Accountable Officer, the commissioner will seek assurance that national regulations and standards are being adhered to. Particular attention should be given to authority to access controlled drugs and controlled drug records.
25. The Provider shall ensure that where appropriate it is an active member of the Controlled Drug Local Intelligence Network.
26. The Provider should be working toward meeting the Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services http://www.rpharms.com/support-pdfs/rps---professional-standards-for-hospital-pharmacy.pdf
27. Support for Self Care and Self-Management

27.1 When appropriate for the indication, The Provider will make patients aware of medicines that are available to buy, advise them to purchase them from a community pharmacy where they can obtain professional advice and not ask the GP to prescribe.

27.2 The Provider will offer opportunistic brief interventions whenever appropriate to advise patients and service users on lifestyle measures that will enable them to get the best from their medication.

27.3 The Provider will support patients with long term conditions to become self-managing in line with the national direction for integrated care.

28. The Provider shall facilitate the participation of the appropriate pharmacy staff in the Local Pharmacy Professional Network
29. The Provider will work with the Commissioner to identify issues and drive improvements in primary care by notifying the Commissioner of adverse medicines related incidents. This may include admissions (where the admitting consultant identifies that the admission is related to a medicines incident this will be escalated to pharmacy and a datix will be logged), any medicines related issues identified from the medicines reconciliation exercise on admission and patients identified from the anticoagulant clinic as having a high INR.
30. The Provider will endeavour to follow the principles and implementation of the National Medicines Safety Thermometer.
31. The Provider will be mindful of the North East Essex locality formulary and prescribing guidelines, recognising that this reflects primary care prescribing rather than secondary care prescribing, and adhere to them where possible.
32. The Commissioner may request that formulary adherence / prescribing audits / antibiotic audits are conducted and the results shared.
33. The Provider will ensure all discharged in-patients (where appropriate) and non-admitted patients (where appropriate) are provided with the required prescription relevant to their stay/attendance in accordance with our policy. We reserve the right to reclaim from the Provider any prescription costs that result from non-adherence to the policy unless specifically agreed in advance.
34. Where a drug is not on the relevant hospital formulary, the secondary care clinician cannot refer back to the patient's GP for prescription of this drug, unless specifically agreed in advance in writing with the General Practitioner. When this is agreed a deduction to tariff payment based upon a locally pre-agreed 'standard' drug cost will be made.
35. Where a device is not included in the Drug Tariff, the prescriber shall not expect the patient's GP to take on prescribing responsibility without prior agreement.
36. Clinical Trials

36.1 Where a patient agrees to be included in a clinical trial the Commissioner will not pick up the costs of drugs or treatments that follow as a result of inclusion in that trial unless previously approved as outlined in this section.

36.2 Treatments resulting from trials that have not been previously agreed may be funded on an exceptional basis by Prior Approval following the appropriate application route to the Commissioner. Authorisation to charge for that standard treatment must therefore be made to the CCG in writing prior to commencement of treatment.

36.3 The CCG does not expect medicines costs of clinical trials to impose a financial burden on it / the local health economy beyond the costs that would otherwise be expected to be incurred should the patients have standard CCG authorised funding for treatment. As a general principle, clinical trials should be cost neutral or cost saving. The Trust will work with the CCG to analyse the cumulative cost impact of clinical trials and then report the overall situation on a quarterly basis.

36.4 Any individual trial that is anticipated to have an adverse cost impact will be discussed with the CCG prior to commencement and agreement sought in the context of the

overall balance of clinical trial excess costs / financial benefits. Failure to obtain CCG agreement may result in costs being borne by the Provider.

36.5 Each research project / trial which includes medicines funded by the CCG will be reviewed at least annually by the CCG with the Provider and have criteria identified that would 'trigger' a review in the meantime. This review would assess the cost implications of the trial and make decisions as to whether the CCG continue to support it. Where a project or trial is not cost neutral or cost saving, the CCG would normally cease to support it and would expect that no new recruitment is made.

APPENDIX C

1. Quality

1.1 Under the Health and Social Care Act 2012 there is a clear statutory responsibility upon CCGs to ensure quality and safe services which states; *'Each CCG must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness'*.

1.2 In 2013 the public inquiry into Mid Staffordshire NHS Foundation Trust and the subsequent publication of the Keogh Review and the Berwick Reports, and Hard truths, the government's response to the Francis Report, demonstrates the commitment made by the NHS to the discipline of patient safety– it is at the heart of every job in the NHS, on the ward, in the GP's surgery, in every community service and all the way through the system to commissioning organisations. The absolute importance of patient safety is also now recognised at every government level from our local authorities to Whitehall.

1.3 NEECCG recognise now is the time to build upon the foundations already laid in North East Essex and make further advances in the world of safety improvement and quality so the legacy of Francis, Keogh and Berwick is that of a confident and learning health system that listens to the needs of its patients and staff in order to deliver the safest and best healthcare.

1.4 NEECCG have fully committed to recommendations made in these reports, and in Hard Truths, the government's response, and pledge to ensure that all contracts include quality performance requirements that reflect the recommendations of these reports, expected core standards of care are secured contractually and challenging providers to make on-going improvements in the quality of care provided.

1.5 NEECCG will seek contractual redress when performance does not meet expected quality and safety standards; whilst working with that provider to improve the quality of services provided for every patient

1.6 During the contractual year 2016/17 NEECCG intend to continue to focus on the incorporation of outcome based measurements into our contracts based on the NHS Outcomes Framework.

2. Operational Standards

2.1 Expect providers to be compliant with the CQC Fundamental Standards, promoting best practice, to regularly monitor and report on on-going compliance with exception reports of non-compliance. Following inspection by the CQC the provider will update us on the outcome of the visit and any subsequent actions.

2.2 Require providers to work within a robust Governance arrangement for all activity.

2.3 Require assurance that Providers are actively engaged implementing any relevant requirements to their services or organisation from recent inquiries or reviews.

2.4 In accordance with the national contract terms, we reserve the right to request audits of the provider's activity and patient care records, to ensure that activity has been delivered in accordance with the requirements of the contract, and that appropriate clinical pathways/clinical outcomes are maintained for our patients. These audits can be both unannounced and announced audits.

3. National Quality Requirements

3.1 NEECCG intends to develop stretching CQUIN targets for 2016-17, ensuring that there is clear evidence of improved quality and patient outcomes. There will be further national mandated CQUINs for providers in 2016-17.

3.2 All CQUINs agreed for 2016-17 (with the exception of nationally mandated indicators) should be considered for alignment to Care Closer to Home to facilitate implementation across the

health economy and care pathways within Care Closer to Home and to continue to improve quality and promote innovation through this period of change.

4. Local Quality Requirements

4.1 NEECCG will require Providers to report against the agreed outcomes in the NHS Outcomes Framework, as well as locally commissioned outcomes frameworks, and take remedial action where intelligence indicates a level of performance below the national expected level.

5. Quality Reporting Requirements

5.1 NHS Safety Thermometer (ST)- All providers will be expected to utilise all safety thermometers relevant to their commissioned services ('classic' ST, Maternity, MH, Medicines, etc. as they come on line) and to demonstrate a commitment to improving safety and supporting innovation by taking part in piloting work when new STs relevant to their services are being developed and tested nationally.

5.2 Sign up to Safety- All providers are expected to sign up and commit to the campaign publicly and report on progress on action plans.

5.3 Reporting for assurance- NEECCG intends to develop and require via contractual reporting that consistent reporting methodologies are applied across all commissioned services for indicators of quality and safety. For example, but not limited to: safer staffing, complaints, incidents, HCAI and patient experience. To change reporting to enable a more granular and consistent whole-economy view of these indicators for CCG by expanding to reporting by individual ward/department/service as agreed most appropriate with CCG dependent on service configuration, and including a mandated list of minimum elements for inclusion, to allow provider to transparently triangulate and report on the quality and safety of the individual service areas and report for CCG assurance.

5.4 Revalidation- The CCG will require assurance that each commissioned provider has a process in place to support its registered nursing staff to achieve the requirements of revalidation and that this system, in whatever format it may be, is monitored by the organisation to provide assurance that all registered nurses will achieve their revalidation requirements ahead of their revalidation date. The CCG will request reports on the number and percentage of qualified nursing staff with logins active for the revalidation online tool and similarly reports on the numbers and the percentage of all qualified nursing staff that are actively using the revalidation online tool.

5.5 The Health and Social Care Act (2008): Code of Practice (updated July 2015) on the prevention and control of infections and related guidance – The CCG will require providers to comply with relevant legislation and guidance on infection control and share regular compliance reports with the CCG.

6. Domain 1 – Preventing people from dying prematurely

6.1 NEECCG expects all providers to adopt new and recommended standards of best practice and evidenced based working to improve the overall care provided to our patients.

6.2 NEECCG will require Providers to attain at least the national average on SHMI (100). Where the Provider fails to achieve this target they will be required to agree an action plan with us, within an agreed timeframe. If a Mortality Alert is issued by the CQC the provider will be required to inform us of the response and any subsequent action plan.

6.3 NEECCG will require Providers to develop and share their clinical audit programme, which includes participation in relevant National Audit to allow benchmarking and comparative analysis.

7. Domain 2 – Enhancing the Quality of Life of people with long term conditions

7.1 NEECCG expects providers to demonstrate progress in four key areas:

7.1.1 involving people in their own care;

7.1.2 the use of technology;

7.1.3 better integration of services;

7.1.4 the diagnosis, treatment and care of those with dementia.

7.2 Provider organisations will be required to involve patients and their carers, and empower them to manage and make decisions about their own care and treatment;

7.3 Provider organisations will be expected to support people to develop the knowledge, skills and confidence to manage their own health, so they can live their lives to the full;

7.4 Provider organisations will be expected to ensure that everyone with long-term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decisions;

7.5 Providers will be expected to work with NEECCG to identify patients who could benefit to be offered the option to hold their own personal health budget, as a way to have even more control over their care;

7.6 NEECCG will expect Providers to ensure that carers looking after friends and family members will routinely have access to information and advice about the support available –including respite care.

8. Domain 3 – Helping people to recover from a period of ill health

8.1 NEECCG will require Providers to develop and share their annual clinical audit programme, which must include participation in relevant National Audits to allow benchmarking and comparative analysis.

8.2 NEECCG expects providers to engage with the development and implementation of recommendations for the implementation of Clinical Networks and Senates.

8.3 NEECCG will require providers to develop pathways of care across a variety of health and social care providers to ensure that mental health care is on a par with physical health, and close the health gap between people with mental health problems and the population as a whole.

9. Domain 4 – Ensuring that people have a positive experience of care

9.1 Providers will be required to demonstrate that effective systems are in place to respond to patient feedback from surveys, complaints and other intelligence, such as patient stories. This will include the need to share themes and trends and improvement actions taken in a timely way. We expect improved responsiveness to complaints, identifying themes and trends to improve patient experience and perception.

9.2 NEECCG will require Providers to share their annual patient experience programmes, demonstrating diverse methodologies to gather patient experience intelligence from a variety of sources, reflecting all commissioned service areas and including real time monitoring, to enable timely responsiveness to areas of concern.

9.3 NEECCG will have a continued focus on Providers meeting single sex accommodation guidance (EMSA), including requiring reporting of any EMSA breaches. RCA will be completed by any provider reporting an EMSA breach.

9.4 NEECCG will require that all patients attending hospital services will receive the same level of service regardless of age, sex, race, sexuality or disability and will require providers to comply with all existing national legislation with regard to the provision of services and for reasonable adjustments to be made to support their access to acute services and for Providers to meet the requirements of the Equality Act 2010 and the NHS Equality Delivery

System (EDS), providers will be required to maintain the EDS or, in the case on non-NHS providers, to have in place similar arrangements that will help to progress the EDS goals.

9.5 Providers will be expected to seek to improve services and service outcomes for people with mental health problems, ensuring services are based on humanity, dignity and respect. This includes measuring, assessing and improving service user and carer experience. We expect the 'No Health without Mental Health, a cross-government mental health outcomes strategy for people of all ages, February 2011 to be implemented.

9.6 NEECCG will seek to improve services and service outcomes for people with Learning Disabilities working with Essex County Council as lead commissioner to look at specific measures and monitoring processes to improve outcomes for patients with a learning disability which will be based upon the outcome of self-assessments of Learning Disability services. Also, in the light of the Serious Case Review into abuse at Winterbourne View, providers will be required to monitor patterns in A&E attendances from residential units for people with learning disabilities.

10. Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

10.1 NEECCG will utilise transparent methodology with respect to on-site visits and inspections of premises and quality and safety of services, which may be either announced or unannounced.

10.2 Providers will be expected to respond to National Patient Safety and Quality Initiatives as they are issued, such as the new CNO vision for Nursing and Midwifery and National Safety Standards for Invasive Procedures.

10.3 NEECCG will commission all services to meet NICE Quality Standards and require assurance of compliance to be provided.

10.4 NEECCG will continue to work across the system to reduce HCAI and will want to address issues in relation to existing MRSA and Clostridium Difficile targets by undertaking investigations of non-MRSA blood stream infection such as MSSA and Ecoli as well as introducing initiatives for surgical site infections and catheter associated urinary tract infections.

10.5 All providers will be expected to deliver and report compliance with antimicrobial stewardship criteria of the Code of practice for the prevention and control of infections (2015) and relevant associated patient safety alerts. This to include collaboration with providers across North East Essex and required upload of data to national databases e.g. PHE to support national and international initiatives to reduce inappropriate use of antibiotics.

10.6 Providers will be expected to demonstrate effective systems to identify and manage sepsis to reduce the mortality associated with sepsis and improve overall patient outcomes. Systems should include collaborative working with colleagues across the health and social care economy.

10.7 NEECCG will support providers in implementing urinary symptom management processes to reduce risks of catheter associated urinary tract infections. This will include the use of catheter passports and care pathways for managing incontinence and retention of urine.

10.8 All Providers will be required to adopt NEECCG Policy in relation to identifying, reporting and investigation of Serious Incidents and incidents. Providers must comply with their duty of candour, being open and transparent with their process and also sharing outcomes with us in a timely manner.

10.9 Providers are expected to evidence that they have robust systems in place for the dissemination, management and monitoring of all safety alerts.

10.10 NEECCG require providers to share their level of achievement with the NHSLA.

10.11 NEECCG will continue to work with Providers in managing and improving quality as per the National Quality Board report – Quality in the New Health System, reviewing the report and the implications for the new health economy.

10.12 NEECCG will work with Essex County Council collaboratively to improve standards of nursing care within care homes in North East Essex. This will include a specific focus on infection prevention & control.

10.13 NEECCG will ensure Providers continue to focus on improving safeguarding of vulnerable adults and children.

10.14 Providers will be required to standardise the approach to the identification and response to the deteriorating patient.

10.15 All providers will be expected to implement additional Harm Free Care programmes and initiatives as they are developed nationally, including taking part in pilot schemes relevant to their services.

11. Safeguarding Adults

11.1 Providers will need to evidence that they follow the Southend, Essex & Thurrock (SET) Safeguarding Adults Guidelines and are expected to participate in the Essex Safeguarding Adults Boards' audits, action planning and sub groups. They will need to demonstrate that they have implemented and used appropriate safeguarding protocols and legislation, in particular safer recruitment legislation.

11.2 NEECCG require evidence of the appropriate use of the Mental Capacity Act, particularly with regard to serious medical treatment, change of accommodation, Deprivation of Liberty and use of IMCA's.

11.3 NEECCG will continue to monitor compliance against safeguarding training requirements within contracts and will treat any underperformance as a serious quality concern and manage the same appropriately, applying any contractual sanctions.

11.4 NEECCG expects that all providers are compliant with PREVENT training requirements and provide reports on the numbers of their workforce that have been trained.

12. Safeguarding Children

12.1 Providers will need to evidence that they follow the Southend, Essex & Thurrock (SET) Safeguarding and Child Protection Procedures (2015) and are expected to participate in the Essex Safeguarding Children Board's audits, action planning and sub groups, including the Health Executive Forum. They will need to demonstrate that they have implemented and used appropriate safeguarding protocols and legislation, including safer recruitment legislation.

12.2 NEECCG will continue to monitor compliance against safeguarding training requirements within contracts and will treat any underperformance as a serious quality concern and manage the same appropriately, applying any contractual sanctions. Training needs to be in accordance with the requirements stated within: 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' Intercollegiate Document (2014) and 'Looked After Children Knowledge, skills and competencies of Health Care Staff' Intercollegiate Document (2015).

12.3 As Corporate Parents NEECCG has a duty to safeguard and promote the welfare of children placed in the care of the Local Authority. Promoting the Health and Well-being of Looked-After Children (2015) outlines the statutory requirements that must be met by all provider organisations for this group of children. All providers must also ensure that practitioners fulfil their roles as identified within the 'Looked After Children: Knowledge, skills and competencies of Health Care Staff' Intercollegiate Document' (2015).

12.4 Female Genital Mutilation (FGM) and its management- NEECCG will expect its providers, where appropriate, to comply with the national recommendations for FGM issues by the Royal College of Obstetricians and Gynaecologists (RCOG) (https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/), including but not limited to:

a) Clinicians must know the difference between recording and reporting female genital mutilation, according to new UK guidance on the issue

b) All acute trusts/health boards should have a designated consultant and midwife responsible for the care of women with FGM

c) All gynaecologists, obstetricians and midwives should receive mandatory training on FGM and its management, including the technique of de-infibulation and they should complete the programme of FGM e-modules developed by Health Education England http://www.e-lfh.org.uk/programmes/female-genital-mutilation.

12.5 NEECCG also expects providers to comply with statutory recording in clinical notes of FGM and statutory reporting of FGM on the HSCIC Enhanced dataset as defined by the Department of Health. http://www.hscic.gov.uk/fgm

12.6 NEECCG require evidence of the appropriate use of the Mental Capacity Act and Deprivation of Liberty in relation to 16 and 17 year olds.

12.7 Providers will be expected to evidence that they follow the Guidance for Threshold of Need and Intervention (2011) and this is embedded into organisational safeguarding practice. http://dnn.essex.gov.uk/Portals/15/Documents/Local%20Practices/ECC%20Thresholds%20Document%20January%202011.pdf

- Providers will be expected to report to the CCG, on request, the number of referrals made for levels 1 -4 services by their organisation to demonstrate the level of need identified within the service.

12.8 Domestic Abuse and its management. NEECCG will expect its providers, where appropriate, to comply with the NICE Guidelines for Domestic Violence and Abuse which includes, but is not limited to:

- Ensure trained staff ask people about domestic violence and abuse
- Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.
- Ensure people who may be experiencing domestic violence and abuse can be seen on their own (a person may have multiple abusers and friends or family members may be colluding in the abuse).
- Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.
- Ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse.
- Ensure all services have formal referral pathways in place for domestic violence and abuse. These should support: people who disclose that they have been subjected to it; the perpetrators; and children who have been affected by it

12.9 NEECCG requires providers to have signed the Essex Multi-agency Agency Risk Assessment Conference (MARAC) Information Sharing Protocol and fully participate in the MARAC

process, to include sharing of information into the process, appropriate attendance at the MARAC and completing actions agreed at the MARAC.

APPENDIX D

Continuing Healthcare

(To be included in all Community, Acute, Mental Health and Learning Disability Providers specifications and contracts as a core requirement)

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, (November 2012, Revised) sets out the principles and processes to deliver a consistent approach to assessing eligibility for NHS Continuing Healthcare for all people with all conditions using a common set of tools. It reflects the new structures created by the Health and Social Care Act 2012 effective from the 1st April 2013 and the legal duties and responsibilities that have transferred to Clinical Commissioning Groups who are now required to discharge this function.

CCGs therefore have a responsibility to ensure that the assessment of continuing healthcare eligibility for care/support and its provision take place in a timely and consistent manner. The Framework states that CCG's should consider how the principles and processes in the guidance relate to what is currently in place and consider where NHS continuing healthcare responsibilities require clearer arrangements to be made with provider organisations and ensure that these are built into commissioning processes. (Revised Framework 2012 DH)

The NHS Responsibilities Directions require CCG's to take reasonable steps to ensure that individuals are assessed for NHS Continuing Healthcare in all cases where it appears that there may be a need for such care. In addition, Department of Health Practice Guidance (November 2012) states the expectation that this shall include all staff involved in assessing or reviewing individuals' needs as part of their day to day work. Such staff should be trained in the use of NHS Continuing Healthcare Checklists & Decision Support Tools with completion of these identified as part of their core roles and responsibilities. Anyone who carries out an assessment of eligibility for NHS continuing healthcare should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs.

The Framework includes the Checklist, Decision Support Tool ("DST"), and Fast Track tools which apply equally to all client groups. CCGs require Providers to be competent and responsible for ensuring consistent application of the framework guidance and tools as set out in the policy. In order to formally note Provider responsibilities in relation to Continuing Healthcare, the intention is to build a number of key requirements into Service Specifications for 2014/15. For the remainder of 2013/14 the key requirements, as listed below, shall be proposed for inclusion within contracts by way of formal variation.

1. Application of Requirements within Contracts

1.1 The CCG quality team will ensure that the requirements below are appropriately included within contract service specifications or, where necessary, agreed as part of the quality requirements schedule.

1.2 Providers must ensure that processes are put in place to identify those individuals for whom it is appropriate to use the checklist tool. Consideration should always be given to whether an individual's needs suggest that it might be appropriate to use the checklist to identify whether or not there is a potential eligibility for NHS continuing healthcare. The assessment process should draw on those who have knowledge of the individual and their needs. Whoever applies the checklist should be familiar with and have regard to the content and principles of the DH Framework Guidance and tools.

1.3 In both the acute and community setting providers must follow the Continuing Healthcare Framework Guidance and take the lead role in completing a checklist:

- 1.3.1 as part of a core community assessment;
- 1.3.2 when a clinician such as a community nurse, or therapist is reviewing a patient's needs;
- 1.3.3 where there has been a reported change in an individual's care needs;
- 1.3.4 as part of a hospital discharge pathway
- 1.3.5 In any circumstance that would suggest potential eligibility for NHS Continuing Healthcare.

1.4 Providers must offer an explanation of the NHS Continuing Healthcare process to the Service User and make clear that completion of the checklist does not indicate likelihood of eligibility.

1.5 Providers must ensure that appropriate informed consent is obtained before the start of the process to determine eligibility for Continuing Healthcare. Where capacity may be lacking, it is a legal requirement that clinicians demonstrate how they have achieved consent (MCA2/Mental Capacity Act 2005).

1.6 Providers must forward completed checklists to the Continuing Healthcare Team for verification and where a checklist triggers 'positive for further consideration', shall work to the 28 day timescale as set out in the Framework for completion & submission of the full referral to the Continuing Healthcare Team.

1.7 Providers must take the lead role of key co-ordinator for community based patients following a positive checklist and will lead the co-ordination of an appropriate Multidisciplinary Team ("MDT") ensuring completion of the Decision Support Tool (DST) and all necessary assessments to facilitate decision making. This shall include completion of a care plan and risk assessment that identifies all care that is required to meet the patients' assessed needs and to manage any identified risks.

Note: Eligibility recommendations must be led by the practitioners who have met and assessed the individual. The MDT must make a recommendation as the Continuing Healthcare panel cannot make decisions in the absence of a recommendation on eligibility from the MDT.

1.8 Providers may be asked to carry out further work on a DST if it is not completed fully or if there is a significant lack of consistency between the evidence recorded and the recommendation made. In such cases a full explanation from the CHC team will be provided of the relevant matters that need to be addressed. Circumstances where a recommendation may be sent back to the MDT will include:

- 1.8.1 Where the DST is not completed fully,(including where there is no recommendation)
- 1.8.2 Where an MDT has not been properly constituted (Recommendations will not be accepted if MDT membership or process has not been followed)
- 1.8.3 Where there are significant gaps in evidence to support the recommendation
- 1.8.4 Where there is an obvious mismatch between evidence provided and the recommendation being made
- 1.8.5 Where the recommendation would result in either the CCG or Local Authority acting unlawfully

1.9 In the community setting providers must undertake an on-going case management role and undertake a 12 week review (and thereafter annually) following award of Continuing Healthcare eligibility.

NHS
North East Essex
Clinical Commissioning Group

APPENDIX E

Mental Health

North Essex CCGs' Mental Health Commissioning Intentions for 2016/17

NHS North East Essex CCG hosts the Mental Health Commissioning function across North Essex, including NHS Mid Essex CCG and NHS West Essex CCG. The Mental Health Commissioning Intentions cover the intentions of all three CCGs.

North Essex CCGs produced a Mental Health Strategy in partnership with Essex County Council in 2014 covering 2014-17.

This Strategy showed how we plan to improve outcomes to all aspects of mental health care. We aim to:

I. Develop and support community well-being and encourage people to maintain healthy lifestyles and keep themselves mentally well. This includes offering therapies to people at times in their lives when they feel particularly anxious and at an early stage, to prevent their mental health from deteriorating into more serious problems
II. Enable people to make choices, take control and be supported by their peers
III. Support individuals to be free from dependency on health and social care services recognising appropriate housing; employment and healthy relationships play an important role. This strategy centres on services that will support people to maintain and strengthen these aspects of their lives
IV. Equip GPs, primary care staff and other community health and social care providers to recognise, assess and support people with mental health needs and to be more effective in treating people's mental health needs alongside their physical health
V. Improve the access and gateway into services so people are directed and provided with the right support at the right time and in the right place
VI. Ensure specialist services continue to develop and are available for people who have severe mental health conditions. It is our intention that wherever possible, short term intensive support will be provided to help people develop skills that enable their recovery
VII. Ensure people experiencing a mental health crisis will get help quickly, from a range of services. Full use will be made of available technology and social media to keep in touch with people at times when they need additional reassurance but do not want or need more intensive health intervention
VIII. Actively support individuals who may not have had access to services previously, including those who are socially excluded – services to 'fit' around individuals, not individuals to 'fit' into services
IX. Establish community wellbeing, supporting and empowering individuals to manage their own mental health
X. Establish integrated primary/community based care for the delivery of mental health services and the management of Long Term Conditions
XI. Develop improved crisis pathways to reduce A&E attendances, admissions and the time people stay in acute beds
XII. Improve access to services and reduce waiting times for assessment, diagnosis and treatment.
XIII. Increase the number of carers receiving support
XIV. Increase the number of people on direct payments or self-directed support
XV. Provide more coordinated care for people with a dual diagnosis

XVI. Provide a more coordinated and seamless service approach for people considered to be frail;

XVII. Improve value for money, e.g. on accommodation and specialist services – this includes moving from residential care to supported housing

XVIII. We will encourage people to maintain healthy lifestyles through the promotion of mental health wellbeing

XIX. We will support the stepped care approach to meet local need. The transitions between each step, including the transition to secondary care services, should be experienced as seamless and the whole approach is predicated on the active involvement of service users and their family and friends

This strategy will be reviewed in 2016 with the view of having a new North Essex wide mental health strategy in place for the beginning of 2017.

We will formally review our delivery of the current strategy.

CCGs will also work with Essex County Council and Essex Public Health to fully update the Essex mental health Joint Strategic Needs Assessment.

1. National and Local Context

1.1 A number of recent documents influence the provision of Mental Health Services including:

1.1.1 Mental Health Crisis Care Concordat
1.1.2 Positive and Proactive Care: reducing the need for restrictive interventions
1.1.3 Winterbourne View Review Concordat: A Programme of Action
1.1.4 Hard Truths
1.1.5 Essex Prevention Strategy
1.1.6 NHS outcomes Framework and CCG Indicator Set
1.1.7 Essex Joint Strategic Needs Assessment
1.1.8 Essex Health and Wellbeing Strategy
1.1.9 NHS Constitution
1.1.10 NHS Mandate
1.1.11 North Essex CCGs Five Year Strategic Plan
1.1.12 Francis Report
1.1.13 Keogh Report
1.1.14 Berwick Report
1.1.15 The Care Act
1.1.16 Future In Mind- Promoting and Protecting Children's Wellbeing

2. Partnership Working with Providers

The CCG will build on the partnership working with its key stakeholders, including our providers where this will benefit patient care and deliver efficiencies across the North Essex healthcare system.

The CCG recognises the benefits of successful joint working, with mutual trust and shared responsibilities and respect for each other's priorities and differences. The CCG therefore reiterates its agreed list of principles to facilitate collaborative working and will expect all providers to commit to and own the following principles:

- Recognise and accept the need for joint working, given our mutually shared objectives and our need to build sustainability across the economy of North Essex
- Develop and maintain trust by respecting our individual roles and responsibilities
- Develop and define clarity of purpose while learning from each other to help build and maintain mutually strong reputations

- Ensure the patient is at the centre of all decision making, and that service developments are driven by the needs of the local population
- Maintain openness, honesty, timeliness and transparency in communication.
- Ensure a commitment to deliver high quality outcomes
- Ensure a "no surprise" culture by committing to early discussion of emerging issues
- Ensure commitment to deliver to agreed timescales, and respond to reasonable requests for information and cooperation

3. Financial Principles

In addition to the principles outlined in the main body of the letter applicable to all providers, North Essex CCGs will:

3.1 Not pay for any service developments and / or associated cost pressures unless approved in advance during the contracting round, and where appropriate following requisite contractual notice of change

3.2 Not pay for services provided to patients who are not registered with a North Essex GP Practice, or chargeable under recognised national guidance, at the time of their treatment. Furthermore, we would expect under a block contract arrangement to be issued with credit notes for non-North Essex GP registered patient usage of inpatient beds

3.3 Work in partnership to unbundle tariffs where pathways span multiple providers, and/or where QIPP initiatives or service redesign supports unbundling

3.4 Review and refresh specific activity & finance terms agreed in existing contracts, to ensure absolute clarity on data validation, contract management rules and thresholds for contractual performance/penalties

3.5 Not pay where counting and/or recording changes are implemented by a Provider without prior agreement from the CCG and, where appropriate notice (generally 6 months) of the financial and activity impact is not given

3.6 Not pay more for the same services, regardless of whether increases are brought about by technical changes such as movement from block to cost and volume, or changes to recording currencies

3.7 Requests for contractual changes (changes to tariffs, not patient care) will require evidence based proposals, with the 6 month notice only accepted from when the proposals have been signed off

3.8 Intend to commission on the same payment and contractual basis where similar services are commissioned from multiple providers

3.9 Performance manage providers who treat patients outside of Clinical Priorities Policy, where treatment has occurred and been charged inappropriately such activity will be zero costed

3.10 Not accept increases (outside of the principles above) to prices for residual services, following a reduction in the level, complexity or breadth of a wider service as a result of planned service changes, changes to contractual arrangements and/or service provider.

3.11 The CCG will, primarily through its procurement process, be looking for innovative ways of managing financial elements of its contracts supporting the move towards outcome based contracts. Payment methodologies will begin to be geared more towards performance/delivery outcomes, rather than purely activity based.

4. Information/ Activity Principles

The CCGs will:

4.1 Work together with Providers in agreeing the activity Plan for 2016-17 taking into consideration the impact of QIPP projects, service reviews and other factors, such as changing referral patterns linked to availability of additional services, Choice, demographic changes and other relevant factors

4.2 Expect SUS to be used as the definitive data source for data and payment for all services that SUS covers. Where SUS data is not complete and/or accurate, or agreement cannot be reached on its use as the primary payment system we reserve the right to continue to request local datasets. A patient record level MDS, reconciled to summary reporting, will be expected for all contracts to enable analysis and validation of data and performance reporting

4.3 Employ standard validation processes across all contracts, and work with Providers to identify and reconcile any differences in outputs from Provider performance reports and CCG validated outputs in line with national timetables. The CCG will only pay for appropriate activity

4.4 Not pay, unless specifically agreed in advance, for activity where the NHS number/GP Practice is not provided. To enable all contracts to be split across CCG's and practices, it is essential that all non-tariff activity and costs are attributed to practices at MDS level using the standard practice codes

4.5 Review outpatient follow-up ratios with performance benchmarked against national, regional and local comparators. There is an expectation that Providers will work to reduce the number of follow-ups, and therefore improve ratios, by the use of telephone contacts, technology and other appropriate means wherever possible – and in conjunction with the commissioner. Where innovative approaches are proposed the CCG will look to negotiate an incentivised basis for reductions. Providers will be expected to at least maintain delivery of current contractual requirements

4.6 Work with Providers to design and deliver a programme of clinical and coding audits, supported by benchmarking and comparative analysis, to validate and review patient pathways and coding and support the management/ monitoring of any thresholds set in contracts and in order to form baselines for future contract standards. This will include clinical audit and will require Providers to co-operate in making available appropriate clinical staff to support this

4.7 Require providers to participate in selected National Audits and via the NHS Benchmarking Network

4.8 As part of contract negotiations, intend to develop an indicative profiled activity plan for all services for 2016/17 and will further develop our approach to monitoring of activity against plan as part of our contract management arrangements

4.9 Identify where CCG services are purchased from a CSU or DSCRO (Data Service for Commissioners Regional Office), and flag any changes that may be required to Provider arrangements for the transmission of datasets, and possibly the format and media of those datasets. We will review and strengthen the exact requirements in Schedule 6 of the contract Particulars and other supporting Information schedules, and these changes will be discussed and agreed with Providers during contract negotiations

4.10 As a result of national requirements for the externalisation of support functions, we need Providers to ensure that the format of datasets received is in line with the agreed contract and are received in that consistent format throughout the year. Failure to provide data in the agreed format, without prior agreement/variation, may lead to files not being processed, and either non-payment or delay in payment

4.11 Include financial penalties in the 2016/17 Contract for the non-provision of information. This will include the consistent and accurate use of the NHS number in all patient datasets. This is subject to review, and where appropriate temporary alternative arrangements, where national guidance or statutory requirements prevent the flow of such data

4.12 Wish to agree a revised Data Quality Improvement Plan (DQIP) with all Providers, and reporting mechanisms to provide continued assurance that key data requirements and milestones are being fully delivered within agreed timescales. This will need to show clear links and planned progress towards the informatics requirements detailed in national guidance

4.13 Expect that for all services the location of any contact is clearly recorded and identifiable

4.14 Review and strive to constantly improve the quality of all activity and referral data, including the development, with Providers, of appropriate processes and quality monitoring mechanisms that make best use of existing and future technologies

4.15 Expect all Providers to provide finance and activity performance reports and supporting local data (where not derived from SUS), in an agreed format and frequency, to enable payment against contracts, and support validation and reconciliation against CCG reports. The CCG will work with Providers to ensure that, where possible;

- 4.15.1 These reports are in a format that allows automated reconciliation with CCG reports,
- 4.15.2 These reports can be generated from existing Provider systems/internal reports to minimise any duplication of effort

4.16 Where providers submit performance and other data to national systems there is often a time lag (of up to one week) before commissioners can extract this data. The CCG therefore requires providers to either;

- 4.16.1 Supply copies, on the day of submission, of all statutory returns made to the following systems; DH UNIFY, Information Centre Omnibus and Health Protection Agency systems, or
- 4.16.2 Authorise, where required, CCG access to unify and/or other systems to enable viewing if Provider returns once they are submitted and authorised. This will enable CCG assurance that the returns have been completed on time, and to provide an opportunity to utilise the data in respect of our population before the returns are made public by the receiving system

5. Sustainability and Resilience

5.1 Building resilience within the local population is seen as being of significant benefit to service users. We will do this by encouraging self-care and self-management; maximising the best use of technology including apps and media tools. We will support the system to develop a shared lives scheme

5.2 We expect providers to work with CCGs on admission avoidance and system resilience

5.3 We expect providers to sub contract an element of their work to the third sector as a means of building system resilience and efficiencies, ensuring robust governance procedures are in place with an expectation of gain share

5.4 We expect providers to play an active role in local system resilience groups and to play a key role in the North Essex wide mental health system resilience group

6. Quality & Service Improvement

6.1 Quality of care remains at the heart of the commissioning decisions made by North Essex CCGs. Whilst some difficult decisions have been made in 2015/16 and can be expected in 2016/17 the CCG will always consider the impact on its patients and ensure that responsible decisions are made

6.2 The CCGs will uphold their statutory responsibilities under the Health and Social Care Act 2012 to ensure continuous quality improvement in the services it commissions. CCGs will ensure that it follows and embeds in its practice and its contracts, the national guidance for improving patient care and safety when this is published, building on the foundations of change brought about by the public enquiry into Mid Staffordshire NHS Foundation Trust and the national publication of reports such as the Francis report and the Keogh Review

6.3 CCGs will strive to improve the quality of care of their patients through the services they commission and will use contractual levers to facilitate improvement in standards of care where performance does not meet the required quality and safety standards
6.4 The CCGs will work with providers to understand their workforce plans to provide assurances that the services they provide are sufficiently staffed with the appropriate skill mix and ratios required. The CCGs will expect transparency from providers to the CCGs and the public on this issue and will expect this information to continue to be updated and published on the NHS Choices website
6.5 During the contractual year 2016/17, CCGs will continue to focus on the incorporation of outcome based measurements into our contracts based on the NHS Outcomes Framework
6.6 Local CQUINs will be stretch targets and demonstrate enhanced quality and innovation in provision of services. We will expect CQUIN targets delivered in 2015/16 to become business as usual
6.7 Work will continued to integrate Mental and Physical Health services and providers will be expected to enhance their relationships with physical health providers to ensure that people with mental health issues have excellent physical health care while in mental health acute and community care settings. We expect mental health providers to take a lead role in the physical health care of their service users in mental health services.
6.8 We will expect physical health care providers to supply mental health providers with all required physical health information to support the care of patients
6.9 Provision of timely access to Mental Health service(s) will be expected for the Complex Pain Patient requiring psychological support beyond the scope of IAPT and in the absence of the Pain Management Programme which has been decommissioned by Mid Essex CCG.
6.10 Commissioners will seek to undertake a North Essex wide procurement for mental health clinical triage services to ensure that service users are seen in the right setting the first time of contact
6.11 Building on the work carried out this year and through the Essex Wide Mental health strategic review, we will review additional opportunities in other clusters to move activity to a primary care or community setting. CCGs expect a further reduction in cluster 1-8 activity within North Essex Partnership Trust in 2016/17
6.12 CCGs wish to influence elements of Providers Audit Plans for 2016/17. Issues will be identified through contracted service delivery
6.13 Commissioners expect a reduction in the number of assessments undertaken by streamlining the pathway along with improving the continuity of care via a named clinical professional
6.14 CCGs are committed to delivering the Parity of Esteem agenda
6.15 Following the Winterbourne review, we expect to reduce the number of placements that are a significant distance from families and friends
6.16 A holistic Physical Health assessment is required to be carried out in order to support access to services. 100% of patients should be offered the assessment and the uptake in assessments will be monitored and is expected to increase
6.17 Carer Support assessments are to be offered 100% of the time with greater use of the third sector via signposting and joint working expected
6.18 Following the publication of the north Essex wide Personality Disorder (PD) Strategy we will review services and undertake any necessary service re-design in order to implement a refined pathway. This will require changes to current provision including reducing the reliance on inpatient beds
6.19 The CCGs will be looking to reduce the usage of the North Essex Partnership Trust inpatient risk share and private sector beds by continuing to reduce the delayed discharges within the system and to ensure admissions do not happen unless clinically necessary. CCGs wish to reduce the

number of beds required within the trust by reducing the reliance on inpatient beds for people with personality disorder

6.20 We will redesign the dementia pathway and will be undertaking a procurement exercise across north Essex to purchase a new pathway for dementia services. This review will include a review of all relevant data relating to the current provision including the use of the Mental Health Act

6.21 We wish to achieve the national dementia diagnosis targets for all north Essex CCGs

6.22 We will be serving formal notice on Cambridge and Peterborough Mental Health Trust to cease our contractual arrangement and will seek to deliver this provision through a subcontracting arrangement with North Essex Partnership Trust

6.23 We expect all national IAPT KPIs are to be delivered and maintained by IAPT providers

6.24 National standards for care in Early Intervention in Psychosis services will be met by providers

6.25 The CCGs will begin implementation of personal health budgets for mental health and will seek to work jointly with Essex County Council to provide joint opportunities with personal budgets

6.26 We will review our advocacy provision to ensure no duplication of provision in services purchased by health and social care

6.27 We will work with our acute providers to seek to transfer the purchasing responsibility for RAID and A & E liaison services. We will ensure acute providers have plans in place in line with national requirements for the expansion of these services to 2020. There will be 24/7 access to a mental health professional at the urgent care centres

6.28 CCGs wish to improve further multiagency working to support delivery of the crisis care concordat and will work with providers to ensure that training will be available to emergency services colleagues to enhance understanding of treatment of people with mental health issues

6.29 In line with the North East Essex CCG strategy of commissioning integrated community teams and providing parity of care for physical and mental health we will work with North Essex Partnership Trust, Hertfordshire Partnership Trust to support the delivery of Care Closer to Home

6.30 We will provide a north Essex response to recovery and social inclusion services and jointly procure new services in the community with Essex County Council

6.31 We will review all of our mental health contracts in place to ensure best value for money in commissioning of services

6.32 We will use the available evidence base to inform our commissioning of services

6.33 We will have contracts in place for all individual placements commissioned for mental health

6.34 We will have an enhanced focus on service outcomes and ensure that good patient and carer experience and improving outcomes remain central to our strategy

6.35 We will maintain a focus on transition between CAMHS and adult mental health services and expect providers of these services to work effectively together to ensure a positive patient experience of transition.

6.36 We will work with Essex County Council to retain a focus on housing and employment services and their links to supporting the mental health system

6.37 We will expect providers to support the management of demand and capacity issues within the trust and to minimise and delays to discharge from inpatient beds. We expect providers to begin to plan inpatient discharge upon admission to inpatient units

6.38 We remain committed to delivery of the crisis care concordat principles and will expect providers to remain actively involved in working groups and delivery

7. The Mental Health Payments System

7.1 We will review national guidance around the development of the mental health payments system. We will implement national guidance where mandated and will work towards delivery of any new systems for example the anticipated ‘year of care’ methodology

7.2 We will continue to work with providers to improve the quality and accuracy of data provided and to improve validation of reporting

7.3 We will consider the financial impact of any changes to national guidance on the mental health payments system to all parties. A financial guarantee/ block guarantee and shadow period of operation may be required as part of negotiations for the first year of implementation of any key changes

8. Waiting Times

8.1 The CCGs wish to ensure that waiting times are maintained in line with national targets. The CCGs will continue to be interested in waits for treatment beyond assessment particularly in psychological therapies. We will maintain a focus on waits to treatment beyond initial assessment

8.2 We wish to have a greater on focus on the time in which service users are waiting for assessment and treatment in all of our services

8.3 Providers will be expected to comply with all national waiting time standards set

9. Medicines Management

9.1 We will work across the system to ensure the prescribing of cost effective medication according to NICE guidance

9.2 We will work across the system to ensure appropriate levels of Antipsychotic Prescribing and to reduce the prescribing of antidepressant medication where psychological therapies may be more appropriate

10. The Journeys Programme

10.1 The CCGs wish to work with the North Essex Partnership Trust to continue to evaluate the impact of the Journeys programme on service user and carer experience of services

11. Primary Care Development

11.1 We expect providers to support the development of mental health in primary care by working more collaboratively with primary care colleagues and to increase flexibility in the use of mental health specialists, including the provision of education and training to primary care colleagues

11.2 We wish to use the evidence base from successful models of primary care based mental health services, such as those in Newham to reduce reliance on secondary care services and to re-procure services with a primary care mental health focus

11.3 We wish to strengthen the primary care and secondary care interface and improve communications between organisations involved in a service user's care. We wish to facilitate a primary care MDT based approach to care

11.4 In Mid Essex CCG, we wish to further build on our community mental health service available for treating service users in cluster 1-8

12. The Essex mental health strategic review

12.1 Essex Clinical Commissioning Groups, Local Authorities and mental health providers jointly commissioned a strategic review on the sustainability and viability of mental health services in Essex. The review concluded in September 2015 and a number of core recommendations for commissioners and providers will be progressed. In line with the recommendations made during this review, Essex commissioners commit to the following principles for future delivery;

- to develop a joint working arrangement across health and social care to reduce fragmentation of commissioning and improve working with providers

- to define what we mean by integrated services in each locality and provide clarity to providers on how we see our mental health services being commissioned in the future
- to develop an Essex wide strategy for mental health which defines clear patient outcomes; and to implement this strategy through the commissioning of outcome based services
- Services will be evidence based, and the local need for services will be clearly quantified based on available data

The recommended actions will be delivered over a 5 year time scale which will include the procurement of new services to ensure services deliver the outcomes required.

13. CAMHS

13.1 We will consolidate the service requirements detailed in the procurement of CYP EWMH in our contract with North East London Foundation Trust (NELFT). In particular, we will focus on moving away from mobilisation and implementation towards service delivery and improved access and outcomes for children and young people. We will be agreeing challenging but realistic targets for improvement against the agreed KPIs and the percentage of contract value assigned to performance will increase to 5%. Our contract for 15/16 set out indicative areas for the 16/17 SDIP and DQIP and these will be reviewed and clearly scheduled for delivery

13.2 We will look to vary the contract with NELFT to include the activity and finance associated with referrals from south of the M25 corridor within west Essex. This is currently dealt with on an NCA basis

13.3 We will roll over our contract for advocacy with MIND and will review in year

13.4 We will be developing plans for perinatal mental health once the national guidance is received

13.5 We will implement the priorities and schemes contained within our Transformation Plan once assurance has been received from NHSE. Transformation will be in accordance with the requirements of “Future in Mind”. Development priorities will include but not be limited to roll out of CYP IAPT working towards full coverage by 2018, developing specialised eating disorder services to meet the defined access and waiting time standards in line with national requirements and building capacity and capability throughout the system

13.6 We will be introducing CAMHS data standards in accordance with ISN SCCI0011 and requiring providers to collect data from 1/1/16 and commence submitting data from 1/2/16