Speicalised Commissioning Appendix

1. Context

Specialised services are those provided in relatively few hospitals/providers, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

Four factors determine whether NHS England commissions a service as a prescribed specialised service. These are:

- The number of individuals who require the service;
- The cost of providing the service or facility;
- The number of people able to provide the service or facility; and
- The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for provision of the service or facility themselves.

In south east London we have nine providers of specialised services and £850m spend, most of which is spent with our two largest providers: Guys and St Thomas' (£410m) and King's College Hospital (£312m), with Lewisham and Greenwich providing a further £43m. Specialised mental health services are provided by South London and Maudsley (£41m) and Oxleas (£19m).The specialised services provided by hospitals in south east London are accessed by a population that goes well beyond London. For example, one third of all activity in south east London is from outside of south east London, with the most significant flows from Kent and Medway and Surrey and Sussex. The size of specialised services in south east London has an impact on the sustainability of our system, both in terms of financial sustainability and the quality of other services.

In September 2016, NHS England published commissioning intentions 2017/18 and 2018/19 for prescribed specialised services. These are primarily based on the new strategic framework for Specialised Care as set out in May 2016. The framework sets out three priority areas for implementation:

- **Delivering place and population based care:** Local level collaboration to agree patient and service priorities, identify sustainable provider configuration and develop options for commissioning.
- **Providing national level support:** National support to enable local flexibility, including reform of clinical advice, improving data and information, support for innovation and improving the prioritisation of new drugs and treatments.
- **Ensuring financial sustainability and value for money:** Putting in place financial controls in ways that provide clear incentives to transform provision and integrate specialised elements with the whole care pathway. The constrained expenditure growth over the next two years provides a shared requirement for greater efficiency and productivity across the NHS for both commissioners and providers.

2. South East London's Case for change

We are facing a number of challenge around specialised services, which we are spending more time understanding through discussions with a range of stakeholders. These include national, regional and local issues, such as:

- The rising demand for specialised services, driven by advances in science and an ageing population with long-term conditions, which have prompted an increased demand for specialist care;
- Increasing financial pressures for specialised services, including the increasing volume of expensive new drugs. Spending on specialised services has increased at much greater a rate than other parts of the NHS, and this is expected to continue;
- Rising public expectation and choice for specialised treatment;
- Pathway fragmentation (duplication of activity, gaps in provision, disconnects between specialised, non-specialised and local services, and treatment not being provided in the most appropriate place);
- Overlaps in provision – an initial scoping of provision across the acute specialised services providers in south London has identified a high level of service overlap, the majority of which aligns to areas of high spend. The close proximity of similar services in south London offers opportunities to increase efficiency, but attempts to change specialised services to create larger and more effective units have often been contested;
- Increased flows from the South East;
- Sometimes London mental health patients are referred to beds/services outside London;
- Children and young people cannot always access age appropriate inpatient mental health services when they need them
- London's neuro rehabilitation service has experienced severe pressure across the range of its services. The patient pathway for each unit shows inconsistencies, creating bottlenecks and blockages both for accessing and discharging of patients;
- Paediatric services operate independently and there are opportunities to standardise and improve the areas of optimising retrieval times, consistency and costs/resourcing;
- Developments in the management of HIV and changes in contracting for sexual health provision means the current configuration of HIV services needs to be evolved to meet the changing environment;
- Performance challenges and lack of consistent delivery of targets across the acute providers, including:
    - Challenges in achieving the 62 day cancer wait target across south east London
    - A large number of patients waiting over 52 weeks in neurosurgery and orthopaedics at Kings College Hospital – the Trust is receiving support to reduce this number, particularly in the identification of Independent Sector capacity

3. 'Do nothing' financial challenge

In June 2016, the 'do nothing' specialised commissioning financial challenge for south east London was estimated at £190m. This figure was a high level provisional estimate and was presented as a cumulative figure over five years.

During September 2016 there has been an intensive effort to review and refresh the 'do nothing' gap, through the development of a finance and activity model that will estimate, at a greater level of detail, the financial challenge associated with pan-London specialised commissioning. This work is expected to be completed in October 2016.

The importance of reconciling growth assumptions between providers and commissioners and having system-wide agreement to the scale of the challenge is recognised. NHS England will engage with the largest providers of specialised services with contract values over £150m and single

speciality providers. The STP's Finance and Activity Committee will be updated throughout this process of engagement.

We will also work with our neighbours and surrounding regions to plan and design schemes to address the gap.

4. Delivering sustainable change

As a consequence of these challenges we, together with NHS England, are considering alternative ways to deliver and plan specialised services.

i. Opportunity analysis

In addition to the quality and performance issues highlighted in the case for change above, which are being discussed with NHS England's London Clinical Advisory Group, the 2015/16 performance data have been analysed to identify opportunities. By identifying incidences of variance for particular service lines between CCGs and between providers, it may be possible to improve quality and reduce cost by bringing them in line with peers. We include below some indicative analysis that we will use to engage with stakeholders and support and guide discussions to identify opportunities for improvement.

Total specialised commissioning spend in SEL

The data on specialised services commissioned for patients from SEL CCGs show:

- The highest spend in SEL is on patients from Lambeth CCG with £113.0m in 15/16
- The total spend in London is £523.5m, which is 21% of the total spend on specialised commissioning in London, and the third highest of the London STP footprints
- The average spend per unit weighted population for SEL is £280, which is 6.1% higher than the London STP average (£264)
- Southwark CCG has the highest average spend per unit weighted population at £314

Total specialised commissioning spend in SEL – total spend on 15/16 activity at 16/17 prices

CCG	15/16 spend at 16/17 prices	Spend / unweighted population	Spend / weighted population
NHS LAMBETH CCG	£113.0m	£341	£294
NHS SOUTHWARK CCG	£98.0m	£362	£314
NHS BROMLEY CCG	£90.0m	£237	£265
NHS LEWISHAM CCG	£85.1m	£295	£272
NHS GREENWICH CCG	£77.9m	£296	£272
NHS BEXLEY CCG	£59.4m	£228	£253
SEL total	£523.5m	£292	£280

The unweighted and weighted population figures are taken from NHSE CCG Allocations 'Calculation of specialised services weighted populations spreadsheet (columns L and J respectively).
Weighting normalises for population size, age, health, unmet need and location factors between populations and is normalised so that the total for England is the same as October 2015 unweighted registrations.

These figures exclude spend on non-London providers, London Probation Trust and Ministry of Justice and SEAP, but include spend on non-SEL providers.

Total specialised commissioning spend on patients from SEL CCGs at all London providers

The data on total spend on patients from SEL CCGs at London providers suggest the following:

- Around 4/5ths of spend on patients from SEL CCGs is at providers in the SEL footprint and 1/5th at providers from the rest of London
- Around 66% of spend on patients from SEL CCGs is at Guy's and St Thomas' and King's College Hospitals
- Of patients in the SEL CCG footprints, the highest spend is on patients from Lambeth CCG
- The highest spend non-SEL provider receiving patients from SEL CCGs is Chelsea and Westminster Hospital with £15.7m in 15/16

Total specialised commissioning spend on patients from SEL CCGs at London providers – total spend on 15/16 activity at 16/17 prices

Cost of 15/16 activity at 16/17 prices £0K – £43,010K		SEL						
		NHS LAMBETH CCG	NHS SOUTHWARK CCG	NHS BROMLEY CCG	NHS LEWISHAM CCG	NHS GREENWICH CCG	NHS BEXLEY CCG	Total
SEL	GUY'S AND ST THOMAS'	£42,539K	£38,433K	£27,987K	£29,892K	£22,727K	£25,624K	£187,201K
	KING'S COLLEGE HOSPITAL	£27,510K	£34,439K	£43,010K	£20,708K	£17,428K	£15,584K	£158,680K
	LEWISHAM & GREENWICH	£114K	£502K	£2,250K	£14,959K	£14,309K	£7,837K	£39,970K
	SOUTH LONDON AND MAUDSLEY	£9,213K	£5,648K	£2,284K	£2,392K	£1,010K	£864K	£21,410K
	OXLEAS	£55K		£1,257K	£3,805K	£9,073K	£1,384K	£15,574K
	THE HUNTERCOMBE GROUP	£104K	£133K	£229K	£442K	£526K	£388K	£1,823K
	IN MIND	£24K	£138K			£146K		£308K
	LONDON AMBULANCE SERVICE	£19K	£19K	£19K	£19K	£19K	£19K	£112K
	Total	£79,577K	£79,311K	£77,035K	£72,216K	£65,239K	£51,700K	£425,077K
NWL	CHELSEA AND WESTMINSTER HOSPITAL	£7,726K	£3,790K	£666K	£1,977K	£933K	£653K	£15,747K
	IMPERIAL COLLEGE HEALTHCARE	£1,678K	£1,135K	£648K	£707K	£854K	£307K	£5,329K
	CENTRAL AND NORTH WEST LONDON	£2,333K	£1,791K	£166K	£423K	£291K	£277K	£5,281K
	ROYAL BROMPTON & HAREFIELD	£1,557K	£752K	£862K	£541K	£675K	£534K	£4,921K
	WEST LONDON MENTAL HEALTH	£499K	£59K	£310K	£393K	£510K	£13K	£1,784K
	LONDON NORTH WEST HEALTHCARE	£246K	£156K	£328K	£167K	£264K	£112K	£1,272K
	TAVISTOCK AND PORTMAN	£58K	£43K	£36K	£60K	£20K	£16K	£232K
	ST PETER'S ANDROLOGY CENTRE	£38K	£62K		£71K		£0K	£172K
	THE HILLINGDON HOSPITALS	£5K	£4K	£14K				£23K
	Total	£14,141K	£7,791K	£3,030K	£4,340K	£3,547K	£1,912K	£34,761K
NCL	UNIVERSITY COLLEGE LONDON HOSPITALS	£2,690K	£1,845K	£1,977K	£1,510K	£1,541K	£1,519K	£11,081K
	GREAT ORMOND STREET HOSPITAL FOR C..	£1,993K	£4,037K	£1,373K	£669K	£1,956K	£990K	£11,018K
	ROYAL FREE LONDON	£1,346K	£1,176K	£914K	£1,345K	£891K	£283K	£5,956K
	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL	£252K	£363K	£412K	£425K	£814K	£401K	£2,668K
	MOORFIELDS EYE HOSPITAL	£258K	£108K	£185K	£135K	£237K	£141K	£1,064K
	LONDON WOUND HEALING CENTRES LTD	£65K	£65K	£65K	£65K	£65K	£65K	£391K
	HOSPITAL OF ST JOHN AND ST ELIZABETH	£39K	£39K	£39K	£39K	£39K	£39K	£237K
	NORTH MIDDLESEX UNIVERSITY HOSPITAL	£2K	£0K	£109K	£3K	£0K	£7K	£121K
	INSTITUTE OF OPTHALMOLOGY	£17K	£17K	£17K	£17K	£17K	£17K	£103K
	BUPA GROUP	£8K		£39K	£15K	£15K	£15K	£92K
	THE WHITTINGTON HOSPITAL	£12K	£5K	£0K	£34K		£17K	£68K
	CENTRE FOR REPRODUCTIVE AND GENETI..	£12K						£12K
	BARNET, ENFIELD AND HARINGEY MENTAL..	£1K	£2K		£0K			£3K
	Total	£6,694K	£7,657K	£5,130K	£4,259K	£5,576K	£3,497K	£32,814K
SWL	ST GEORGE'S	£7,887K	£932K	£1,607K	£693K	£620K	£379K	£12,119K
	THE ROYAL MARSDEN	£1,389K	£618K	£1,190K	£1,098K	£850K	£773K	£5,918K
	THE ROYAL HOSPITAL FOR NEURO-DISABI..	£599K	£284K	£230K	£628K	£413K	£109K	£2,262K
	SOUTH WEST LONDON AND ST GEORGE'S ..	£696K	£112K	£155K	£261K	£63K	£35K	£1,321K
	EPSOM AND ST HELIER UNIVERSITY HOSPI..	£213K	£5K	£162K	£49K	£4K	£27K	£460K
	CROYDON HEALTH SERVICES	£341K	£28K	£52K	£7K	£1K	£9K	£439K
	KINGSTON HOSPITAL	£12K	£6K		£1K	£4K		£24K
	OAK VIEW	£0K				£0K		£0K
	Total	£11,137K	£1,985K	£3,395K	£2,738K	£1,955K	£1,332K	£22,542K
NEL	BARTS HEALTH	£1,160K	£1,107K	£1,047K	£1,133K	£1,355K	£830K	£6,633K
	EAST LONDON	£230K	£132K	£305K	£229K		£4K	£901K
	HOMERTON UNIVERSITY HOSPITAL	£28K	£7K	£56K	£144K	£189K	£92K	£516K
	BARKING, HAVERING AND REDBRIDGE UNI..	£51K	£57K	£14K	£52K	£10K	£15K	£198K
	NORTH EAST LONDON	£0K	£1K		£3K		£6K	£10K
	Total	£1,469K	£1,304K	£1,422K	£1,561K	£1,555K	£947K	£8,257K
Grand Total		£113,018K	£98,049K	£90,012K	£85,113K	£77,872K	£59,388K	£523,452K

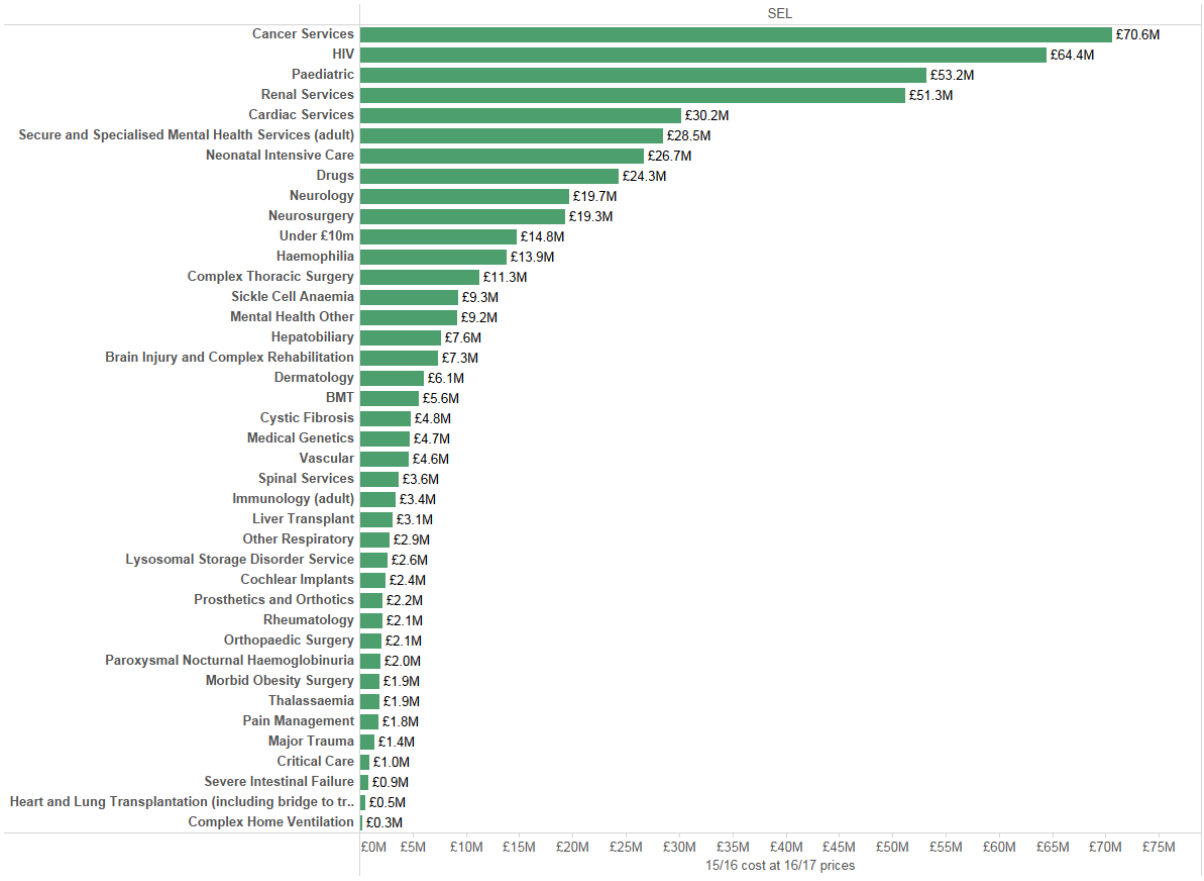
These figures exclude spend London Probation Trust and Ministry of Justice and SEAP.

Service line spend in SEL

The data on service line spend on patients from SEL CCGs suggest the following:

- The highest spend group of service lines in SEL are Cancer Services with a spend of £70.6m in 15/16
- The top five spend service line groups in SEL are, descending (in brackets: % of total SEL spend on all service lines, % of total London spend on the service line):
    - Cancer Services £70.6m (13% of SEL, 21% of London)
    - HIV £64.4m (12% of SEL, 27% of London)
    - Paediatrics £53.2 (10% of SEL, 22% of London)
    - Renal Services £51.3m (10% of SEL, 24% of London)
    - Cardiac Services £30.2m (6% of SEL, 15% of London)
- SEL spends a higher proportion on HIV compared to other STPs – the average spend by STPs on HIV is 10% of their total spend. Overall HIV is the fourth highest spend in London.

Total spend on patients from SEL CCGs on service lines – total spend on 15/16 activity at 16/17 prices



Note that the service line group 'Under £10m' includes all service lines which individually have a total London spend (incl. all STP footprints) of less than £10m.
These figures exclude spend London Probation Trust and Ministry of Justice and SEAP.

4.2 South East London priorities

Through initial discussions and review of opportunities we are suggesting three areas of focus that the system should explore: Transformation pathways; Drugs and Devices; and Improving Value. These ideas will be the subject of on-going discussions with stakeholders, in order to shape more detailed plans:

4.2.1 Transformation pathways

In order to improve the quality and outcomes of specialised services across London, south east London will engage in a regional approach to pathway transformation, focusing on:

- The development of a whole system, pathway led approach to provision and commissioning of services, particularly where transformational change is required, maximising primary and secondary prevention to manage demand;
- Understanding the variation that currently exists across the region and identifying opportunities to challenge this in order to ensure equity of access, outcomes and experience for all patients. This will include working with other commissioners to ensure that care pathways work in a consistent way to support this in all areas;
- Building upon our knowledge of patient flows and the functional relationship between services to work with commissioners and providers to determine new and innovative ways of commissioning and providing services, in order to improve quality, safety and cost effectiveness.

Our initial transformation priorities are as follows. Development of these areas will be clinically led with a clear scope of work defined.

i. Aligning services across south London

Specialised services account for £1.3bn expenditure across South London and as such the disposition of these services is highly significant in ensuring the successful delivery of our STP. In south London we have eight acute specialised providers, including three large providers with contracts over £150m (Guy's and St Thomas', Kings College Hospital and St George's) which are geographically extremely close – the furthest distance between them is just 7 miles. Between them these providers not only deliver a high number of acute specialised commissioned services, but there is also considerable overlap in provision.

Across south London a programme of work has been initiated focused on the scenarios for the future optimal configuration for clinically and financially sustainable acute specialised services that deliver the best patient journey. This work will also consider the patient flows into London from the South East.

This work is at a very early stage of development. By December it is expected to deliver a base case and initial scenarios for future service configuration. In taking forward this work, we will need to understand the impact of these scenarios on access for patients, particularly for any patients whose nearest service would, under one or more of the scenarios, be outside south London. We would also need to consider the financial implications of any movement of services, and the impact on the overall financial balance of the health economy. The modelling would also need to feed into the assessment of other acute configuration scenarios being considered through this STP. The scenarios and their implications would need to be fully understood and discussed with the public before being taken forward.

ii. Service specific pathway transformation

We are also closely engaged with the work underway at a London level to improve the quality and effectiveness of services for patients and ensure resilient provision, by concentrating on five key themes:

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

A programme of pathway reviews has been established by NHS England focusing on services where there are significant patient flows across London and beyond. The initial priorities for work are paediatrics, cardiovascular, specialist cancer, and renal. Work is also underway to address some of our local challenges, based on service overlap analysis, with a focus on neuro-rehabilitation, HIV, adult mental health, CAMHS and Transforming Care Partnerships.

Kings Health Partners (comprising GSTT, KCHT and SLaM and Kings College London) is a key driver of this work to develop specialised services. This work recognises significant opportunities to improve the coordination between specialised and local care through network models, and consolidate the specialist elements of these services with research and training across the specialist sites. Further detail of each of these is set out below.

This work could lead to some changes in service delivery so we will take the views of patients and a wide range of other stakeholders in determining how to deliver the most effective and high performing services.

London Region Priority: Paediatrics	
Context	The development of paediatric services across London incrementally and over time has resulted in fragmentation. This is exacerbated in some services where there are multiple commissioners across a single pathways. Paediatric critical care is a good example of this.
Areas of focus	A review of critical service interdependencies needs to revisited; the aim is to ensure that children and young people can access safe, high quality and holistic specialist care in an environment which is appropriate to their care needs and wherever possible is close to home. The paediatric workforce is changing and there is a significant challenge in maintaining training, optimal workforce standards and a critical mass of patients to maintain skills and expertise. Work to date suggests that these issues might be best addressed through formally established networked models of care.

	Further work is required, in collaboration with maternity services, to support prevention right from the prenatal stage, through the early years and into transition where non-compliance can lead to significant deterioration in chronic health. There are two national service reviews which are underway in paediatric intensive care and in specialist surgery in children. These, together with a transformational review of the neonatal service and implementation of the congenital heart disease standards are likely to lay the foundation for change.

London Region Priority: Cardiovascular	
Context	• Value – there are some more cost effective and improved patient outcomes treatment alternatives • Variation – there is a significant variation in length of stay, even for the same procedure • Referrals – inadequate referrals for some procedures sometimes result in sub-optimal care for patients • There is no organised pan-London plan for the procurement and roll out of new technology
Areas of focus	• Networking and transport arrangements need to be improved to reduce waiting time and improve outcomes • Set up for formal comprehensive networks, with five central units linked with several local units (for vascular) • Set out specific standards that need to be adhered to and propose improved pathways • Integrated pathways, with better prevention, identification, early intervention and access to new treatments • Formalising South London vascular network arrangements

London Region Priority: Specialist Cancer	
Context	• We support the alignment of our STP plan with specialised cancer commissioning plans, so that the wider health system spending supports improved outcomes and value along the whole care pathway. • Earlier diagnosis – there is a need to diagnose cancer earlier in order to improve survival outcomes • Differences in clinical and organisational practice cause variation in the quality of service offered to cancer patients across London • In London there are unnecessary follow-up attendances and these can be in non-optimal settings
Areas of focus	• Deliver priorities of the national cancer strategy, including: ○ Delivery of 62 day standard and 2 week wait

	○ Reduction in variation ○ Earlier identification- through enhanced diagnosis and better access to services through implementing stratified pathways in outpatient services ○ Enhanced access to smoking cessation services to reduce incidence. • Right-sizing - The centralisation of specialist services has benefits both for patients and the services. Some of London's cancer services should be consolidated to ensure minimum numbers/populations are met (Urology/Liver/Pancreatic/Head & Neck/OG/Lung) • Active participation and then implementation from the national service review programme which will include radiotherapy; chemotherapy; cancer surgery; children's and young people's cancer services and a second phase of PET CT • Development of plans for implementing panel and genome testing • Active participation in best practice work to improve value, such as chemotherapy doses, radiotherapy, and levels of intervention for end of life care • Strengthened provider networks across the specialised commissioning pathway portfolio. We will work with the cancer alliance in south east London to ensure the delivery of commitments for improved quality and cost effectiveness in relation to specialised services • We will continue to address non-compliant cancer pathways which do not meet agreed activity thresholds. We will work within the framework of the national strategy to address paediatric cancer services in London

London Region Priority: Renal	
Context	End-stage renal disease affects 0.1% of the population. Treatment for this life-threatening condition is through renal replacement therapy (RRT), this is either by dialysis at home, in a unit or through a kidney transplant. Within London there are over 6000 people receiving dialysis at one of seven renal providers at a cost of c.£212m (2014-15) whilst the national numbers of new patients starting dialysis appears to have stabilised the London dialysis population has grown by an average of 4.4% a year since 2007. The key risk factors for developing kidney disease are: • Diabetes, High Blood Pressure, Heart Disease and a familial history of kidney disease. Of these Diabetes remains the most common primary diagnosis in new patients presenting for renal replacement therapy (38%).. Across the STP 38.8% of diabetes patients had achieved all three of the NICE recommended treatment targets (2014/15). Secondary prevention in primary care, better cooperation and data sharing between primary and secondary care to support early detection of renal disease to improve

	recognition and treatment of chronic disease. Innovative ways of managing renal demand are being explored. • Financial – spend on renal cannot continue to increase without impacting other areas of medicine, and London has lagged behind England in increasing best practice tariffs • Fragmented – commissioning tends to reward activity, rather than support value and patient experience – providers assume responsibility for patients very late along the patient pathway and care often seems fragmented • Prevention – early diagnosis and prevention is key. In 2011/12 there were just under 183,000 people aged 18+ on the London CKD QOF registers, and it is estimated that there could be a further 150,000 with CKD in the SCN who are currently undiagnosed

Areas of focus	• Understand and reduce variation – stabilise prevalent dialysis population in London by 2019, reduce incident patients by 20% per annum, reduce late presentation to under 10%
	• Improve delivery and experience of care in Acute Kidney Injury (AKI) (deliver London's AKI through LAKINetwork
	• Optimise the patient experience of renal care through
	  ○ Establish and share pan London best practice
	  ○ Support shared decision making and patient autonomy in care
	  ○ Access to end of life care
	• Evolve commissioning through provider collaboratives, or Networks of Care (incentivise provider collaboration and openly report any variation on outcome, experience and value to promote best practice
	• Upskill the whole health economy workforce to shift the emphasis on care to one of patient empowerment
	• We will also focus on:
	  ○ Improved early diagnosis and intervention of renal risk factors in primary care to reduce incidence and delay onset of end stage renal failure, hence improving outcomes for patients and reducing demand on costly interventions
	  ○ Increase the number of patients receiving home dialysis
	  ○ Improve the use of technology in follow-ups and support for patients in virtual clinics

Local Priority: Neurorehabilitation	
Context	• Inconsistencies in the patient pathway – creates bottlenecks and blockages for patients accessing and being discharged from the service. • Resources not aligned to where they are most needed for patient care – leads to inefficient way of commissioning and providing the service. • Inconsistent levels and access to care – and care that is not always joined-up around the patient.
Areas of focus	• There has been a London wide review of neurorehabilitation which focused on opportunities to reduce waits, duplicate referrals and deliver

	longer term cost benefits through a better understanding of patient pathways. The review recommended: ○ Developing a data system to collect referrals, which will be used for bed management and waiting list initiatives. ○ Referring centres which will be linked with CCG and NHS provision. • Neuro-navigators to support people moving into CCG and NHSE funded beds. review neuro rehabilitation services in London

Local Priority: HIV	
Context	• London services combined provide care for over half of all people living with HIV in England. • Current configuration of services needs to be reviewed – there are changing needs of an increasing, and ageing, patient population and there is a need to ensure HIV services continue to meet demand. • Opportunities provided by new models of care – these could enhance the health and wellbeing of people living with HIV including their access to primary care, and opportunities for greater self-management. • Significant clinical and service interdependencies exist between HIV and GUM clinics – many share management structures, staff and premises. London Councils are currently taking forward a Sexual Health Transformation Project which may include some reconfiguring of GUM and other sexual health service provision. There is a need to consider any potential impact for HIV services which may arise from changes proposed as part of that work.
Areas of focus	• To ensure the future sustainability of HIV services • To develop a model of NHS England commissioned care that meets the needs of people living with HIV now and in the future, and which is integrated across commissioned pathways • To ensure the most efficient use of resources, both financial and staffing in a consistent way across London • To work closely with London Councils to seek to retain the beneficial links between HIV and GUM commissioned services • To re-examine and update previous work and bring the overall review process to completion • To also explore opportunities for supporting self-management which could give people living with HIV more control of their own care, improve clinical outcomes, and help to reduce or prevent avoidable hospital attendances.

Local Priority: Adult Secure Mental Health Services	
Context	• Fragmentation of services • Inefficiencies in pathways

	• There are three mental health providers across south London (South London and Maudsley, Oxleas and South West London and St George's) • The services covered include all medium secure, low secure, step down and community forensic services covered by the contracts agreed between NHS England and these three Trusts as well as Out of Area
Areas of focus	• Developing a programme across south London to improve access to and experience of care for patients wherever they are from in south London – and whether they receive treatment in south London or Out of Area. • Our ambition is to improve overall service quality, improve the patient and carer experience, and increase the efficiency and productivity of our services. This will be achieved through: ○ The establishment of a new commissioning and case management directorate, with a new team, new patient register and tracker function, and oversight of all transactional and clinical pathway activity required to maximise efficiency and productivity ○ A single point of access for south London for referral, assessment and triage, with a new clinical case management offer across the whole pathway with linked budgetary responsibility ○ Developing specialisation through agreeing what the right distribution of services is for both clinical efficiency and patient pathway optimisation. For example we will consider a single women's pathway. We will use this option to take a fresh look at our estate development, and if appropriate prepare and share recommendations for redevelopment and rationalisation across the partnership; ○ We will invest in reablement, shifting care to a strong step down, rehab and community forensic offer, integrated with housing and welfare providers to ensure safe recovery on transition from inpatient provision ○ We will standardise pathways, advancing quality by building on existing approaches to quality improvement. We will improve throughput (flow) and patient outcomes, actively monitoring protocol compliance. We will also look at commissioning pathway services (particularly substance misuse and PD services) that have been shown to reduce lengths of stay within low secure settings – all evidence suggests that through better pathway management, treatment is timely and more effective, and importantly recovery is quicker. • All four Boards have agreed to the initial proposal in preparation for the pilot to commence in October 2016 in shadow form as the appropriate governance and collaborative mechanisms are established. Full go live is planned from April 2017.

Local Priority: CAMHS	
Context	CAMHS services are provided across the spectrum of care settings with some of the most complex and/or high risk cases requiring admission to specialised

	(T4) inpatient care. Local Transformation Plans are expected to result in a significant reduction in demand for Specialised CAMHS services within the next 5 years. Community crisis care pathways that can provide robust and sustainable alternatives to inpatient care are under-developed particularly for children and young people with complex needs and behaviours related to learning disability (LD) and/or Autism and emerging personality disorders. The overall distribution of CAMHS inpatient capacity does not match Regional population needs and young people are being admitted far from their home, or to paediatric or adult beds; the NHS England National CAMHS Service Review aims to redress service deficits by redistributing/realigning beds to meet local needs, the clear expectation is that by 2020 there will be no inappropriate admissions to adult or paediatric beds and patients will be treated in local care pathways.
Areas of focus	• STP to promote commissioning of consistent out of hours services for young people particularly to manage crisis and prevent escalation with clear ambition to manage demand effectively at community level and reduce inpatient admissions to be reflected in Local CAMHS transformation plan (LTP) refresh and Transforming Care Partnership (TCP) plans. • TCPs with engagement and support of NHS England to oversee consistent delivery of multi-agency pre-admission Care and Treatment Reviews for children and young people with LD, and/or autism to reduce inpatient admissions with ambition reflected in LTP refresh and TCP plans. • NHS England Specialised Commissioning Team to work collaboratively with CCG and Local Authorities commissioners to design and commission effective community pathways with robust links to local acute inpatient services with ambition to reduce lengths of stay and inappropriate placements reflected in LTP and TCP. • NHS England Specialised Commissioning Team to continue to work local commissioners to reflect ambition in LTP/TCP and STP plans to ○ ensure Regional inpatient capacity meets requirements so out of region admissions become the exception ○ to reduce variation by introducing standardised access and waiting times ○ adopt consistent models of care based on best practice that reduce the reliance on inpatient care ○ deliver seamless age-related service transitions

Local Priority: Transforming Care Partnerships	
Context	NHS England Specialised Commissioning is responsible for commissioning high secure, medium secure and low secure inpatient services for adults with

	Learning disabilities and/or autism and for commissioning specialised inpatient care for children and young people with Learning Disabilities and/or autism. There is currently an over-reliance on inpatient-based care for both adults, children and young people and a significant number of patients could be managed out of hospital with the right support. Where a period of inpatient care is required there can be lengthy waits for an appropriate service particularly for children and young people. Lengths of stay for all patients are often extended because of a lack of appropriate community-based alternatives to enable timely discharge particularly where needs are complex. London does not have sufficient inpatient capacity to enable all patients to receive care close to home and a significant proportion of patients are placed out of area primarily in the private sector.

Areas of focus	By working closely with local commissioners within the Transforming Care Partnerships to
	• deliver a robust approach to implementing the pre and post admission Care and Treatment Reviews to reduce the numbers of people particularly children and young people being admitted to inpatient care unnecessarily
	• support the design of appropriate community packages enabling timely discharges and reduced lengths of stay
	• deliver care closer to home by commissioning appropriate inpatient capacity for
	  ○ medium and low secure services for adults
	  ○ specialised inpatient care for CAMHS

4.2.2 Drugs and devices

High cost drugs and devices (HCDD) are "passed through" directly from providers to commissioners and represent a substantial (almost 30%) and growing proportion of south east London attributed spend. The major components of this spend are:

- Cancer drugs
- HIV drugs
- All other drugs
- Devices

Within London, south east London stands out as having the highest levels of HIV treated patients and thereby for incurring a disproportionately high level (on a weighted population basis) of HIV drug spend. Although this contributes to making SEL the highest per capita STP territory in the Capital in absolute terms it is only number 3 once demographic weightings have been reflected.

We intend to work closely with clinical colleagues and partners to bring forward system-wide benefits to improve the value that the NHS gets from our significant investment in high cost drugs and devices through:

- Aligning priorities and improving efficiencies relating to medicines optimisation and the "Hospital Pharmacy Transformation Programme".
- Working with NICE and the CRGs to ensure that treatment algorithms for medicines reflect optimal use of the most cost effective treatments and enable a reduction in unwarranted variation.
- Implementing digital developments such as e-prescribing, electronic prior approvals and standardised contract reporting.
- Completing the centralisation of the high cost device supply chain and reducing the variation of specifications for devices.
- Incentivising Trusts with a medicines optimisation and devices CQUIN for 2017-19 to support implementation.
- We intend to engage with patients and carer representatives on the CRGs on the medicines optimisation programme to improve the value and outcomes for patients.
- Major savings opportunities within HCDD which have been identified and are part of an active QIPP programme include:
    - Two high cost biotech cancer drugs (Rituximab and Trustuzumab) which come out of patent in the next two years. The maximisation of savings will require an aggressive conversion programme from the branded medicine to the "bio-similar" alternative
    - A focus on maximising the national procurement leverage when applied to the purchase of devices
    - A programme targeted at maximising the savings from HIV generic drug availability through substitution and reconfiguration of tablet combinations

4.2.3 Improving value

In line with the national commissioning intentions we will engage with these important areas of work to drive improved value:

- Fragile services – reduction in occasional practice, non-contracted activity, and address non-compliant services which do not meet agreed activity thresholds
- Improved clinical and operational efficiency, and reducing variation, including the use of the clinical utilisation reviews, Rightcare and Getting It Right First Time,
- Implementation of national reviews
- Clinical Reference Group initiatives which will set out opportunities to deliver improvements, whilst achieving a reduction in overall cost.
- London QIPP programme for 17-19, and use of national CQUINs

5. Enablers

5.1 Collaboration

We will take a more collaborative approach to commissioning services on a STP or multi STP footprint. This will include planning and designing services together and providing financial

incentives for pathway improvement, supported by the pooling or delegation of budgets as appropriate. This will be taken forward in south east London in 2016/17 through a collaborative commissioning approach to adult secure mental health services as described above. We will also explore the allocation of budgets across other pathways such as back pain management, neurosurgery and neuro rehabilitation pathways. As part of New Models of Care work we will put Lead Provider/Alliance arrangements in place to develop proposals to secure future sustainability and improve the quality of service.

5.2 Engagement with the National Strategic Service Review Programme

We will engage with a rolling Strategic Service Review Programme approach that is being developed by NHS England to address local service issues. We will work with the national team and Clinical Reference Groups.

5.3 Improving quality

We will commit to:

- Better information – quality dashboards and a quality surveillance system for providers and commissioners accessed via secure portals, which will continue to be developed to deliver better information on patient outcomes, cost/value and quality to enable and inform change
- Quality profiles – quality profile will be generated for each specialised service delivered by any given provider, summarising information from quality surveillance and identifying national outliers.

5.4 Reforming the payment system

We will support:

- Tariff redesign to support outcomes
- Shared contract models – risk/gain share arrangements; longer two year contracts and contract innovation, such as the recovery oriented payment approach in secure mental health services

6. Governance and delivery plan

6.1 Governance

Since our June submission, governance arrangements for Specialised Commissioning planning in London have been agreed. The SEL STP has its Governance arrangement and delivery agreements primarily through STP Heads of Delivery, with a Specialised Commissioning Planning Board to assist on development.

A Specialised Commissioning Planning Board and Specialised Commissioning Executive Board, and localised working groups (including for south London and with the south and midlands and east regions to discuss flows and planning across regional boundaries) have been established. South east London providers and the STP are fully engaged in these structures.

6.2 High level plan for Specialised services