NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Commissioning Intentions

Strategic Approach

Introduction

As the Commissioner responsible for the commissioning of population health services in Cambridgeshire and Peterborough we would like to share with you our approach to commissioning for the next three years.

Traditionally these intentions have been very transactional and have given specific details of the services and contractual opportunities. This document will not do this. Instead, this document will provide you with the framework of the important areas we will ask you to work with us on and the context within which we will be having those conversations.

For the purposes of this document we would like to acknowledge there are some things that are a given. The first is that patients and the public are at the heart of everything we do. It is also a given that all decisions will be based on data and evidence, and prioritised in accordance with clinical and financial risk. Finally, we should all work on the assumption that we are moving to an Integrated Care System (ICS), and that we will therefore work transparently as partners.

Overarching Principles

Starting with the philosophy of commissioning, we believe that our role has five key principles:

1. We will ensure best value for the public pound to address the health needs of the people registered within Cambridgeshire and Peterborough. This means we will constantly work to assure all contracts provide the expected clinical and/or financial value.

2. Commissioners have an accountability to manage the market. We will incentivise providers to work together to get maximum efficiency and effectiveness for our population.

3. Contracts will be agreed on a multi-year basis and will be set at limits we have the cash to pay for. We will not 'QIPP' (Quality, Innovation, Productivity and Prevention) contracts after they have been signed to get money 'refunded' to meet our financial obligations.

4. Where procurement decisions need to be made, we will move to integrated contracts at the level of neighbourhood, place or system as appropriate.

5. Where possible, we will direct our money to local providers for local services and reduce the amount of money leaving the Cambridgeshire and Peterborough STP system.

Clinical Leadership and Quality

We will continue to build on the work being undertaken across the system to drive improvements in Quality across the board. Each Provider Quality Improvement Programme will feed into the Joint Clinical Group to establish system learning. The Chief Nurses, Medical Directors and other senior Clinical Nurses and Clinical Staff will be open and transparent in relation to patient safety and quality and will work on a 'no surprises' basis.

As we continue the development of our Integrated Care System we will bring together Patient Safety and Quality roles and work together to maximise these functions.

When we make commissioning decisions and undertake complete pathway redesign we will work collaboratively through the Joint Clinical Group.

Working with the Public

The CCG will include the outputs of the 2019 BIG conversation in the commissioning of new pathways and services.

This work will continue to evolve, and we will develop innovative engagement programmes both in-house and with partners, such as Healthwatch.

The CCG understands the value of listening to people's experiences. We are committed to creating a culture whereby people's voices are integral to service design and delivery and learning from feedback is the norm

Primary Care Networks

The Primary Care Networks (PCNs) are fundamental to the future of healthcare services being delivered to local people going forward. Therefore from 2020/21 we will focus specifically on their development, aiming by 2022/23 for the PCNs to be the material providers of out of hospital care, working across boundaries to provide seamless pathways for patients when they need access to secondary care services.

We will work with the PCN leaders to ensure we have a clear plan for how resources could be moved into them over time.

Financial Assumptions

There are three pieces of information we need to triangulate to ensure we make the right financial commissioning decisions. These are the five-year allocations, the five-year control total and the Long Term Plan (LTP) investments.

Whilst we acknowledge that our allocations increase year on year, the CCG is rightly expected to improve its financial position year on year in terms of its control totals.

Investments provided to deliver the LTP are often non-recurrent or assumed within the baseline and ring-fenced for target use only.

We have already had Guaranteed Income Contracts for the last two years with some acute providers within our STP. We would like to move away from Payment By Results as the mechanism for pricing and move to Cost of Delivery transparency in multi-year agreements.

The CCG will meet its statutory obligations to primary care and the Mental Health Investment Standard (MHIS).

Only demographic growth will be applied to contracts. Any further financial increase will only be given to providers if they are able to prove they have met their productivity requirements and have justified increased costs that are agreed by their provider peers.

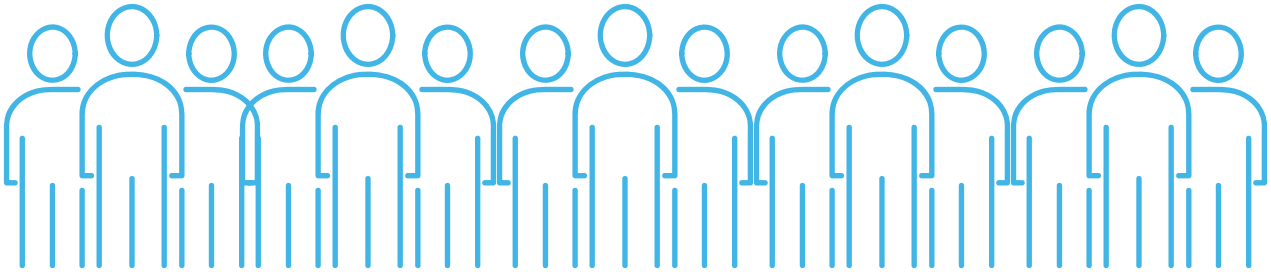
Risk Management

In our current system there is an inequity in managing utilisation and volatility (in other words, demand). For community, primary care and the voluntary sector volume increase is not the basis for a contract value increase and providers have been expected to evolve and absorb this risk for some time. We will reduce this inequity going forward.

From April 2020, we will not be negotiating any non-demographic growth for material providers within the STP (as stated earlier in the document). This means we will be asking providers to work together more across primary and secondary care and reduce volatility.

Demographic Growth

The current financial system for our allocation means that there is a lag between the CCG population growing and the CCG reviewing the allocation for the population growth. Therefore, this lag will flow through into the providers from 2020. Additional allocation to account for demographic growth will only be given once the CCG has received the funds.



With the support of the regional regulators, the CCG will continue to lobby for a new way of working to ensure the population size is updated more regularly, ideally at least quarterly.

Integrated Commissioning

Over the next three years we will continue to work with colleagues in our local authorities. Where we have successfully agreed baselines and growth assumptions between health and care over multiple years, we will (whenever possible) have an integrated health and care commissioning agreement.

Transformation

Going forward all transformation programmes will be undertaken by providers with facilitated support of commissioners. Our role is to set the required outcomes and drive improvement through identification of unwarranted clinical variation.

Over the coming two years we will provide system-wide integrated reporting of performance and delivery. Areas for improvement will be identified where possible on a pathway and system level.

Why are we taking this approach?

The Cambridgeshire and Peterborough system has been in financial distress for too long. By taking the approach above we will create:

Predictability – with clear contract values on multi-year deals

Accountability and flexibility – by providing an incentive to co-ordinate care across settings and providers

Find out more

Keep up to date with the latest news and updates from Cambridgeshire and Peterborough CCG by visiting **www.cambridgeshireandpeterboroughccg.nhs.uk**

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