**NHS Central London CCG Commissioning Intentions 2014/15**

We want to share an early draft with providers and stakeholders in early November 2013 particularly so we can engage widely to deliver the transformational change and sustainability in the health economy that our patients and population want to see. Also, this publication supports our obligations to provide notice of commissioning and decommissioning intentions. A more detailed version will be available by the end of 2013. This should be read in conjunction with the CCG's long-list of projects and contract changes that we expect to implement in 2014/15 and which are included here as an appendix.

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**Commissioning Intentions 2014/15**
**NHS Central London (Westminster) Clinical Commissioning Group and Westminster City Council for jointly commissioned services**



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**Document Information**

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| **Description** | This document sets out the expectations regarding the way that NHS Central London CCG will commission from providers during 2013-14 |
| **Cross references** | • Joint Strategic Needs Assessment and Health and Wellbeing Strategy<br>• Shaping a Healthier Future<br>• CCG Out of Hospital Strategy<br>• National planning guidance |
| **Supersedes** | Not applicable |
| **Action required** | All provider Chairs and Chief Executives should understand commissioners' intentions for 2014-15 in preparation for implementation through the contractual negotiations. |
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**Contents**

**Foreword**

Dr Ruth O'Hare
Chair of NHS Central London Clinical Commissioning Group

As the Chair of NHS Central London Clinical Commissioning Group (CCG), I am committed to commissioning and delivering a service that gives patients and our clinical colleagues the confidence that we can balance excellence in clinical quality while maintaining our financial duties.

The CCG is fully committed to the principles of the NHS and sees its core function to commission high quality health services, delivered in the most cost effective way for its patients. We are committed to supporting the NHS Constitution, ensuring choice and enabling shared decision making. Indeed these commissioning intentions are designed to meet the needs of our patients and population as identified in the Joint Strategic Needs Assessment (JSNA). We also support the delivery of the NHS Mandate and will work in partnership with the NHS Commissioning Board to deliver our mutual objectives.

Whilst there has been significant change in the organisation of the NHS, our commissioning strategy is an evolution of work begun in 2010 (and before) and builds upon initiatives already in operation such as the Patient Referral System (PRS). Integration of health and social care, or taking a 'whole system' approach, will be key to delivering the services we aspire to, building on Westminster's long history of successful joint commissioning work with the Local Authority. Wellwatch, an innovation supported by Central London CCG member practices and now operational, marks a significant start to a new way of working.

Working with Local Authority colleagues we will develop interventions that empower patients to stay healthy for longer, prevent ill-health and reduce health inequalities and put the needs of patients first to ensure the co-ordinated and integrated delivery of health and social care.

We have had a number of successes in our first year as a full statutory organisation which I know is helping patients and the population to stay well. In terms of outcomes, we are continuing to improve services so that fewer people need an unplanned admission to hospital. We are also changing service provision and have introduced services for people needing support with their mental health and widening patient choice to talking therapies. We have also introduced projects to support vulnerable groups including the homeless. These commissioning intentions continue the work that we have started.

We have a clear vision for the future described in our three year Out of Hospital Strategy 2012-15 which was published in May 2012. This strategy describes our plans to effect major change in the way services are provided locally during the strategy's lifetime. We will ensure high quality planned care pathways to reduce the numbers of attendances, work towards a single patient record and patient centred care,

To achieve the ambition of the strategy a significant shift of activity and associated shift of funding from the hospital sector to the community sector and primary care is required. Our strategy aligns closely with plans to reconfigure hospital services across North West London as contained in the "Shaping a Healthier Future" (SAHF) programme. In developing our strategy we have also been working closely with Westminster City Council.

In conclusion the main themes of our commissioning intentions can be summarised as improving quality, ensuring innovation, improving productivity and supporting prevention which will enable the CCG to fulfil its ambition of delivering high quality integrated services.

If you would like to talk to us about our commissioning plans, or indeed anything else, we welcome you getting in touch with us at clccg@nhs.net.

## 1. Executive summary

This document outlines the commissioning intentions for Central London CCG for 2014/15 and builds on the commissioning plans implemented in 2013/14. They reflect the 2014/15 implementation of the CCG'S longer term strategic vision and the medium term financial strategy, and set out the areas where the CCG wishes to contract differently, improve quality or transform service delivery. For further information relating to the CCG'S strategy, please see the following documents:

- CCG Out of Hospital Strategy
- Shaping a Healthier Future
- Health and Wellbeing Strategy
- National planning guidance
- Medium Term Financial Strategy

2014/15 will be the first full year for implementing our health care transformation programme in NW London, Shaping a Healthier Future which sees the creation of 5 major acute hospitals and unprecedented investment in Out of Hospital services. The CIs across CWHHE reflect the scale and pace of this ambition.

The challenge facing the NHS over the next 5 years is immense. Annual growth in NHS resource is lower than it has been for a decade, demand for services is increasing and, with the creation of the Integration Fund, the need to work jointly across the health and social care system is made explicit while also representing a substantial financial threat to the NHS if integration is not achieved. This challenge cannot be met with more of the same, or through incremental change around the edges of NHS services. In these commissioning intentions we seek to make widespread, transformational change across our health and social care system to deliver a step change in the quality of services and the experience of patients while enabling the system to remain financially viable. We expect the providers of the services we commission to respond to the changes we are seeking to make.
As part of this we expect that to commission Whole Systems Integrated Care in shadow form for parts of our population and we will be working ever more closely with our Local Authority partners to do this.

To signify this deepening relationship the commissioning intentions for the community and mental health trusts are written jointly by the CCG and Westminster City Council and cover the services that we both commission from these providers.

The CIs are written at two levels. At a strategic level they provide a consistent and coherent framework across the Tri-borough (Westminster, Kensington and Chelsea, Hammersmith and Fulham local authorities), Hounslow and Ealing health systems and at a local level they set out the detailed service changes that reflect the strategy for each health economy.

The table below summarises the commissioning intentions and the provider sectors which they affect, and demonstrates the linkage between those commissioning intentions and the CCG'S strategy.

| | Strategic fit | | | | | | Provider sectors impacted | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Commissioning Intention | SAHF | OOH strategy | JSNA | H&WB strategy | Mandate | National priorities | Primary care | Community | Mental Health | Acute | Continuing care | Voluntary sector |
| Integrated care and community services | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| Integration fund | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | |
| Urgent and emergency care | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | | |
| Primary care | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Nursing and residential care | | | | | ✓ | ✓ | ✓ | | | | ✓ | |
| Planned care | | | | | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| Cancer | | | ✓ | | ✓ | ✓ | ✓ | | | ✓ | | |
| Mental health | | | ✓ | | ✓ | ✓ | ✓ | | ✓ | | | |
| Learning disabilities | | | | | ✓ | ✓ | ✓ | | | | | |
| Autism | | | | | ✓ | ✓ | ✓ | | | | | |
| Children's services | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Services for carers | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Public health | | | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | |

*How we work*

In April 2012 Central London; West London; Hammersmith & Fulham; and Hounslow CCGs formed a collaborative to share a leadership team and work together on areas to enable them to become effective commissioners. Ealing CCG decided to join the Collaborative which we expect to take place from 1st December 2013 and, collectively, we are known as CWHHE.

The decision to collaborate was reached because the CCG'S felt that this configuration would best:

- Enable each CCG to tackle cross Borough issues and give the maximum influence over decisions that span multiple CCGs such as Trust FT applications or the ongoing negotiation and management of contracts with key providers.
- Enable CCGs to influence the shape of the provider landscape in NW London.
- Facilitate the work required to ensure financial viability of the NW London Health system.
- Enable the CCGs to achieve economies of scale and attract talented individuals to the key leadership roles in NWL CCG Executive structures.
- Enable the CCGs to manage the performance of the Commissioning Support Service.

*Principles and model for collaboration*

CCGs are membership organisations so the ways of working across the CCGs should enable the members to have a lead on all decisions. In practice this could mean that members agree with Chairs the parameters of decision making that the Chairs are delegated by the members to take on their behalf. Therefore decision making does not become an onerous task which requires extensive forums and complicated governance and process. Chairs will be able to delegate authority to individuals in a CCG that can make decisions on their behalf.

The collaborative organisation works to the following principles:

- Recognising the sovereignty of the CCGs and that CCGs are membership organisations.
- Working as a collaborative when we can demonstrate that it will best serve the patients of the individual CCGs.
- Having strong clinical leadership drawn from the CCGs and their Governing Bodies.
- Demonstrating subsidiarity with the majority of decisions being made by the CCG members.
- Having governance arrangements, such as succession planning and delegation procedures, that facilitate continuous and timely decision making.
- The collaborative does not create an additional performance management structure in the system.

**2. Strategic contracting principles and intentions**

We have a number of strategic principles and contracting intentions that are consistent across all providers and which will form the basis of our contracting approach for 2014/15. These are set out below.

*Strategic contracting principles*

We expect all providers to:

- Be working towards the implementation of Shaping a Healthier Future, and delivering on the key changes required such as the implementation of the service standards and the improvements in efficiency and length of stay
- Work with us to integrate services across the patient pathway to ensure that patients experience seamless health and social care services
- Move towards a single patient record through the implementation of new systems that are compatible with the GP IT system or through ensuring interoperability of existing systems with the GP IT system
- Demonstrate continuous improvement in the quality of the services they are providing to patients
- Work with us to reduce non elective admissions to hospital through better management of patients in the community and improved patient pathways within A&E
- Work with us to upstream care so that we move from a model of reactive unplanned care to planned care for the treatment of long term conditions
- Ensure that activity that has been decommissioned as part of QIPP schemes is discontinued, with appropriate reductions in capacity, and to actively work with CCGs to safely transfer patients to the alternative services
- Demonstrate that they have systems to capture, collate, interpret and understand the implications of patient and public feedback and that they are implementing changes and improving services based on that feedback
- Demonstrate how they are monitoring the equalities profile of their service users and examining what that information tells them about cohorts that are over or under-represented in their services
- Work with the CCG to ensure that patient experience is used to inform the provision of services that are compassionate, safe, effective and responsive to meet the clinical, social and personal needs of patients, carers and the wider public
- Actively engage with their staff to enable them to embed the NHS England's '6Cs' into ways of working with patients, relative and their supporters. The 6Cs are: care, compassion, competence, communication, courage and commitment
- Design services around the patient to avoid unnecessary multiple trips to hospital, particularly for specialist diagnostics and opinions. This should also be cost releasing
- Provide alternative models of care that enable GPs to gain rapid access to consultant expertise through hotlines, emails or other technology.
- Prioritise prevention, health promotion and the reduction of health inequalities by embedding them into service delivery and referring as appropriate into local public health, community and voluntary services

*Contracting Intentions to apply to all providers:*

- We will only pay for acute services based on SUS data for those services reported through SUS
- We will not pay for internally generated demand where there is a primary or community service that could better manage the care of the patient or where the pathway generated by the internal referral does not make sense for the patient
- Our local CQUINs will be focused on delivering real, innovative service transformation to improve outcomes for patients
- We expect all providers to be achieving at least upper quartile performance across a range of benchmarked indicators
- If patients are admitted to hospital then the GP should be informed within 24 hours and will be directly involved in the discharge planning for the patient
- Collection of the critical care quality measures data set: all providers are required to comply with and contribute to additional data sets as requested by the NW London Critical Care Network during 2014-15
- We expect provider to have all clinics and services available on Choose and Book as directly bookable service and to have good slot availability.
- We expect all providers paid for under an activity related payment system such as Payment by Results (PbR) to achieve the required Monitor tariff deflator
- For all providers paid under block contracts we expect them to apply the Monitor tariff deflator to all prices
- We will no longer commission local enhanced services from GP practices. Instead, a range of additional services will be commissioned under the standard NHS contract from practices or other providers. The full details are set out within the primary care section of these commissioning intentions.

  *Services that we wish to commission consistently across all our providers*

  Central London CCG has chosen to work collaboratively with: Ealing CCG, Hammersmith & Fulham CCG, Hounslow CCG & West London CCG because we recognise that, while the way in which we implement service change will differ to reflect the differing needs of our populations, the strategic goals that we hold are shared. We are working jointly across a number of areas:
    - Implementation of Shaping a Healthier Future, and the Out of Hospital Strategies that it supports
    - The development of Whole Systems working to deliver more integrated care across health and social services
    - The implementation of a new service model for community nursing
    - The procurement of a new service model for musculoskeletal services
    - Shared contracting intentions for our major NHS acute, community and mental health providers

**3. CCG specific commissioning intentions**

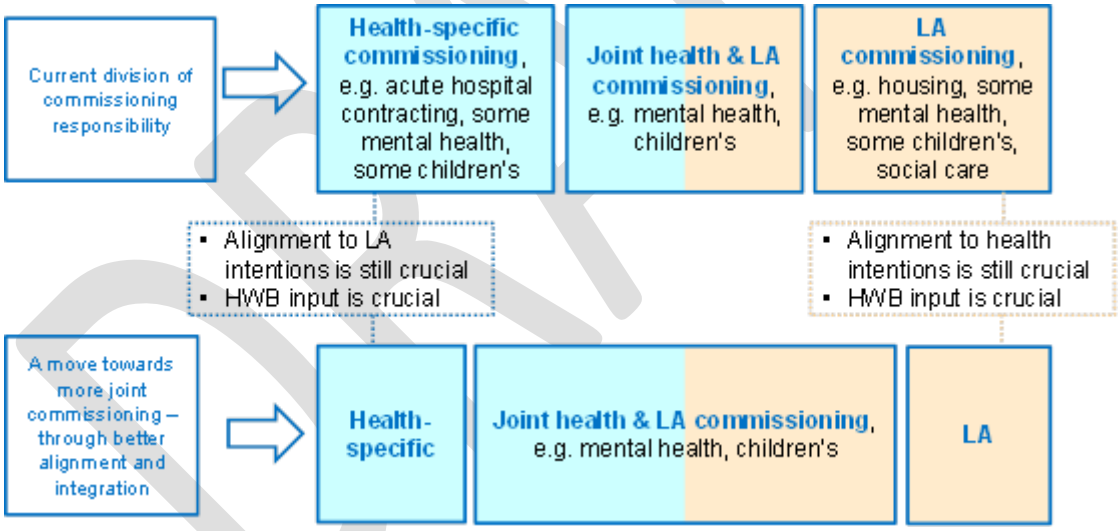
We have organised our commissioning intentions according to the following categories: CCG, LA or joint intentions.

Central London CCG has clear vision and priorities for delivery in 2014/15 (and beyond). Our vision states that:

> "We are committed to delivering care at the right time across integrated care pathways, which are coordinated across the health, social, community and voluntary sectors. We will put our patients at the centre, and develop a system that delivers recovery-focused patient outcomes".

Our direction is based firmly on a number of key strategies, none of which are new and represent the second year of our plans as a statutory organisation; our strategy for out of hospital care and the reconfiguration of hospital care. These both informed our one year commissioning intentions, our operating plans and the specific projects that we want to deliver. We have a current pipeline of projects listed which will be implemented or continue to be delivered in 2014/15 and determine our commissioning intentions; this is included at appendix 2.

It is our aspiration that over time, we move to a position where much more is joint – through both better alignment and through integration, as illustrated below.




We have engaged widely in order to develop these intentions, including across the CCG Governing Body and Membership and the CCG team. We have also involved patients, carers, service users and their representatives and the LA, including the joint commissioning team.

More information about how we have engaged with people is given in the stakeholder engagement section of this document, along with some of our plans for continuing engagement.

In all areas, we recognise that our commissioning intentions for this year are consistent with the direction of travel we established in 2013/14. We have descried the progress we have made as well as the areas where want to strengthen our focus and/or address gaps. This year, we have structured our intentions so as to reflect the key themes of our work, including integration.

### 3.1 Integrated Care Including Community Services

Across CWHHE we have begun the process of designing a new model of care for the parts of our populations we think would most benefit from an integrated approach from commissioners and providers. The co-design period is bringing together partners from across NWL including service users (lay partners), commissioners and providers from across health and social care to address some of the key questions for integration.

The recommendations that are developed through co-design will be taken forward, adapted and tailored for local implementation at borough level, with commissioning decisions made jointly by local authorities and CCG boards. It is anticipated that a number of 'early implementation' sites will launch in shadow form from April 2014 and these sites will receive investment support to implement their plans. The sites will demonstrate the impact of new models of provision while new funding arrangements remain in shadow form through 14-15. A programme of on-going evaluation and shared learning will run in parallel to these pilots. Based on this learning, we would then expect sites to go live in April 2015 with a real flow of integrated funds to providers. We will be asking for expressions of interest to be a Wave 1 site in December 2103.

A "toolkit" is being developed which will provide information on a) analysis of population needs, b) potential payment models, c) potential provision models. It is envisioned that this "toolkit" would be used to inform partners wishing to consider expressing their interest and also in then developing their plans further.

Applications will need both commissioners and providers to detail their integration plan. Health and social care commissioners, in partnership with NHS England where necessary, will need to explain:

- What population they feel would most benefit from integrated commissioning and provision
- The outcomes they want to achieve for this population
- The budgets that will be contributed and the whole care payment that will be made for each person requiring care
- How they will performance manage providers against the outcomes required
- The governance arrangements they will make between each other

In response to this specification, providers will need to provide an explanation of:

- The group of providers who will work together to deliver this care and the responsibilities of each member
- The care model that will be used to deliver better care
- What resources are currently used for the target population across all these providers
- How they can deploy these resources to deliver better models of care in order to achieve the outcomes required
- Governance and organisational arrangements for provider model
- How risk and savings will be distributed between providers
- Information requirements for outcomes, financial payments and people information is needed and how it will be provided
- How the proposed provider group will work within existing system

Based on the Whole Systems Integrated Care work, our commissioning intentions for integrated care will focus on the following client groups:

- Frail older persons

- People with complex needs
- Long term conditions
- Vulnerable adults with physical and mental health care needs.

*Integrated Care – Joint Intentions*

*Community Independence Service (CIS)*

Across the Tri-borough, health and social care, we have a shared commitment that:

- people are enabled and supported to stay as healthy and independent as possible for as long as possible
- People are supported to live in the most appropriate place according to their choice and needs and are able to maintain maximum control over their lives.

Our new approach to Community Independence will replace a range of existing services currently operating at the interface between hospital and community with a best practice model, building on national and local experience. It will be part of and consistent with the wider whole systems approach being developed for 2015-16, meeting both emergency and planned needs of people with short and long term conditions.

*Description of approach*

A network of integrated services will be delivered by a multi-disciplinary team who will work in an integrated way to ensure the patient pathway is seamless, reduces duplication of assessment and ensures the correct outcomes are achieved. The service will utilise the resources of traditional sets of professionals in a more integrated way to create multi-disciplinary teams to enable them to deliver seamless pathways for the patients. The network will operate as *one service*, from both a clinical and a patient/service user perspective.

Services will maximise patient independence, by supporting and treating individuals in their own home or community thereby preventing and / or delaying admissions into hospital and institutional care placements.

Services will deliver tailored packages of support, flexing to people's needs and enabling people to remain at home.

*High level outcomes*

- To enable individuals to be as healthy and independent as possible maintaining and / or regaining their quality of life and well being.
- To support individuals choice to live in the most appropriate place that they want according to their needs and to have control over their lives.
- To ensure that the individuals experience is a positive one by ensuring the service is personalized and seamless within the system.
- To ensure that the treatment, care and support that is provided is right for the individual's needs, in the right setting and respects their individuality and dignity.
- To increase integration and efficiencies across health and social care to ensure strategic investment of funds and resources to maximise value for money.

The CIS will be jointly commissioned by the three CCGs and the Tri-borough Local Authority Adult Social Care team. There will be joint accountability for the care delivered through a single governance structure.

*Wellwatch*

Our local model of integrated care is Wellwatch. Now into its second year, Wellwatch will continue to work closely with partner organisations – Social Care, Environmental Health and a number of other community and voluntary services - to enable those with long-term conditions to stay well for as long as possible. Wellwatch will also continue to work closely with the Integrated Care Programme (ICP) to further develop the service and link it into the overall integration, whole systems work.

The section above sets out our vision for community services that provide a more integrated approach and more seamless care for patients. In addition to this care model we have the following initiatives for 2014/15.

*Community - CCG Intentions*

Intentions for 2014/15

- Respiratory Service Redesign of the Community Respiratory service to effectively manage patients with long-term conditions
- Dermatology community service re-tender
- Gynaecology community service redesign
- Direct Access diagnostics
- CWHHE will also work with other CCGs as appropriate to procure and implement a new wheel chair service.
- Sharing of homelessness data to enable the monitoring of individuals use of clinical services giving CCGs more holistic information from which to work
  To implement Telehealth solutions across the CCG and link to the SystemOne upgrade

*Community Nursing Services*

The CCGs remain committed to aligning resources to the needs of patients using a population-based approach based upon General Practitioner registered lists aggregated to form identified networks of care. This approach is a fundamental component of the Pioneer Whole Systems Integration Plan. Progress has been made in 2013/14 to align the existing district nursing services to networks of care. And we have begun the process of sharing patient records through a common approach to clinical records.

In order for the CCG to move to the next stage of integration it is necessary to understand in more depth both the needs of the registered populations and the current patterns of service delivery for the district nursing service. The former will be taken forward through the whole systems co-design. However in relation to understanding the current caseloads of district nursing service the CCG plans to work with CLCH to understand:

- The sources of referral to the district nursing service including the predicted care need by the referrer and the outcomes following assessment by the service

- The types of care being provided by the service by functional type and pathway eg:

  Tissue viability / wound care function
  Medication prompting functions
  Independence functions
  Continence functions
  Continuing care functions

- The locations from which care is provided, intensity of interventions, length of time on caseload and discharge destination

  working with CLCH, the CCG will use this information to re-design district nursing services, moving towards a more integrated model of care delivery and optimising the role of the practice as the coordinator of care. It is anticipated that to achieve this transformation may require the CCGs and CLCH identifying a forward-looking academic institution to work with over this period.

A summary of the current and potential future projects for this area are summarised in appendix 2.

**3.2 Integration Fund – Joint Intentions**

The Integrated Transformation Fund (ITF) will be a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between CCGs and local authorities.

In 'Integrated care and support: our shared commitment' integration was defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

The ITF does not come into full effect until 2015/16 although the government think it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and 2015/16.

Central London CCG are required to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan needs to also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.
Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

*Conditions of the full ITF*

The ITF will be a pooled budget which will be deployed locally on social care and health provision, subject to the following national conditions which will need to be addressed in the plans:

- Plans to be jointly agreed
- Protection for social care services (not spending); as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health
- Ensure a joint approach to assessments and care planning
- Ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- Agreement on the consequential impact of changes in the acute sector.

We need to have a two year plan for integration fund ready for January 2014. With our Health and Wellbeing Board we need to agree a timetable that delivers the following:

Step one (October/November 2013):

- Mapped out all the existing joint funding arrangements both covered within specific NHS social care transfers and other agreements with each Borough

- Agreed which services in this mapping are priorities
- Agreed the spend for 13/14
- Agreed how reablement funding is currently being used and assured that it is being used for reablement services
- Understood the impact of budget reductions on social care for 14/15 and 15/16

Step two (end of November 2013) we will have agreed our plans to:

- Achieve 7 day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Enable better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning
- Ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Risk sharing principles and contingency plans if targets are not met
- Agreement on the consequential impact of changes in the acute sector and how to mitigate
- Joint governance arrangements to oversee this

Step three (by end of 2013/early 2014) we will have:

- Produced a joint delivery plan with the Tri- borough.

### 3.3 Urgent and Emergency Care – CCG Intentions

The CCG'S Out of Hospital Strategy has rapid response to urgent healthcare needs as one of its key priority areas. The CCG will continue to work to ensure that patients requiring urgent or emergency care are treated in the timeframe and setting appropriate for their needs. We will continue to work to reduce unnecessary Urgent Care Centre and A&E attendances and avoidable hospital admissions by fully utilising alternative services in the community.

Specific areas of focus in 2014/15 will include:

*Urgent Care Centres*

- Retendering of UCCs for St Mary's Hospital, Hammersmith Hospital and Charing Cross Hospital
- Development of the model for GP practices to hold appointments for redirection from Urgent Care Centres or 111
- GP weekend opening for non-urgent redirection, especially at the weekend.
- Ambulatory Emergency Care – co-designing with primary care a service model with each provider on how these conditions will be treated
- IT – is interoperable with SystmOne in all UCCs
- Full roll out of MCAP decision making software in Medical Admission Units
- Urgent care – emergency cap: Retain the emergency admissions cap on activity that is in place at Chelsea and Westminster NHS Foundation Trust and Imperial College Healthcare NHS Trust and implement a similar approach at other acute providers
- Admission Avoidance / Rapid response teams – we will commission 7 day a week services operating 08:00 – 23:00 with emergency night service for admission avoidance available to access from GPs / UCC / A&E.
- Commission medical capacity in the community to support the Community Independence Service and particularly the rapid response service with admission avoidance, including an older adult physician
- Development of direct communication links between LAS and GP practices to reduce unnecessary hospital attendance, building on the pilot carried out in 2013/14
- Develop mechanisms for GP practices and CLCH to support patients who frequently attend A&E or are admitted as emergencies through care planning and case management
- Use of Co-ordinate My Care for management of end of life care and ensuring full utilisation of CMC by GP practices, community teams and LAS to allow more patients to receive terminal care support in their place of choice
- Information sharing – develop mechanisms to enable LAS, 111 and GP OOH services to view care plans
- Patient education – the CCG will carry out targeted patient education activities to raise awareness of ways of accessing urgent care
- Based on monitoring of services commissioned using "winter pressures" funding during winter 2013/14, we will commission on a recurrent basis those services which can be shown to have contributed sufficiently to the effectiveness and efficiency of the whole system to make baseline funding a worthwhile investment.

CWHHE are committed to ensuring that they commission services from Trusts that meet the agreed London Quality Standards for Consultant delivered care seven days a week. The CCG will therefore agree a trajectory with each provider, depending on each starting point, aiming for full achievement by 17/18 as set out in the table below:

| Speciality | Clinical Standard |
|---|---|
| A&E | 16 hours / day |
| Emergency Surgery | 12 hours / day |
| Emergency Medicine | 12 hours / day |
| Critical Care | 24 hours / day |
| Maternity | 24 hours / day |
| Paediatrics | 14 hours / day |

- GP Out of Hours – the contract for opted out practices (practices where the CCG contracts on behalf of the practice rather than the practice directly contracting with an out of hour's provider) will be re-procured in early 14/15. Integration with the 111 and UCC will be key
- 111 – The CCGs will continue to monitor the current contract with a focus on achieving the KPIs for service delivery including redirection. We will work with NHSE following their evaluation of the service enabling us to determine revised specification and procurement requirements. The contract will be renegotiated in-year dependent upon call volumes.
- Respond as required to the NHSE Urgent and Emergency Care Review led by NHSE Medical Director Professor Sir Bruce Keogh.

CCGs in NWL commission the North West London Critical Care Network (a local & Operational Delivery Network) in conjunction with Acute Trusts to oversee the development and support the performance of safe, effective and evidence based critical care services in accordance with national and international guidance and best practice.

Commissioners will work with the critical care network and local Trusts to deliver London safety and quality standards, network quality measures for critical care to fulfil the national critical care specification for 2014-15. This will include the collection of the critical care quality measures data set; all providers are required to comply with and contribute to additional data sets as requested by the North West London Critical Care Network during 2014-15.

As part of the 2014/15 contract negotiations we will seek to agree with providers key improvement areas, recognising the financial, operational and strategic implications of the change required to achieve full compliance.

Recognising the rehabilitation requirements of critical care survivors, the NWL integrated care pilot will be including critical care discharged patients in primary care planning and primary care case conferences to reduce morbidity in critical care survivors and their carers, post discharge, from 2014. Providers will support information flow from ICUs to deliver primary care rehabilitation and case management for these patients

A summary of the current and potential future projects for this area are summarised in appendix 2.

### 3.4 Primary Care –CCG Intentions

The CCGs in North West London are working together to deliver transformed, sustainable primary care. At the heart of this work is the intention to improve the quality of general practice and reduce the known variation while ensuring a thriving and successful primary care service which best meets the needs of our local population. Working with NHS England the CCGs in CWHHE and BHH will continue the work started in 2013/2014 to determine what good quality general practice might look like and what models of care could support this. CCGs in CWHHE will undertake a piece of work to understand the variation in funding across general practice and will then work with NHS England to find a mechanism that enables us to move a fairer funding system during 2014/2015 and beyond.

#### 3.4.1 Recommissioning of Local Enhanced Services

From April 2014 CCGs will no longer have the ability to commission local enhanced services from primary care providers; instead CCGs will be required to commission any out of hospital services required using an appropriate and proportionate procurement process and the NHS Standard Contract as the contracting mechanism.

As a consequence CCGs are reviewing all the local enhanced services that have been commissioned and are concluding which services that they wish to retain. We recognise that we have not been required to undertake a similar exercise covering such a significant proportion of provider income for any other provider, and so we are seeking to be constructive in the way that we approach this task to ensure that we do not destabilise primary care, but instead ensure that it remains sustainable and viable as a key part of our strategy for out of hospital services.

The arrangements have not yet been finalised and are subject to review. However, we expect to apply the following principles in our decision making:

- High quality, financially sustainable primary care is vital to the strategic direction of all the CCGs, and so no financial savings will be sought through the review. Current levels of expenditure across the 5 CCGs will be at least maintained, and investment will be made in some areas
- All services are being considered from the perspective of the patient. We will therefore be seeking to integrate care and provide it as holistically and as close to home as possible where this is in the best interest of the patient and where value for money can be demonstrated. We will be ensuring that where appropriate, the integration of services for the patient will outweigh the fragmentation of service provision through procurement
- Transitional funding arrangements will be considered for providers whose income is materially affected by the changes from LES, to enable them to manage the change and continue to provide safe services to patients.
- Services that are currently commissioned through LES will be either decommissioned; recommissioned in their current form using a standard NHS contract or recommissioned to a different service specification using a standard NHS contract

- The CCGs have developed a draft Commissioning Framework to support decision making for the re-commissioning of Local Enhanced Services based on the draft guidance issued by Monitor. This will be subject to review as and when the Monitor guidance is finalised. The framework is included at Appendix three.

- Future models of primary care are currently being developed. All CCGs are currently exploring ways of working across networks of practices to best provide care for their patients, and this is likely to lead to many services that are currently provided through LES being provided in future by a network of practices providing services to their own patients or on behalf of other practices within the network.. We see this model as key to the delivery of whole systems integrated care and initial reviews suggest that there are a number of services where primary care is most capable and 'best able' to deliver those services

- In line with this, where practices are commissioned to provide services at scale for their patients or for patients from other practices within or across networks, the practice will be required to meet minimum quality standards before they will be able to do so

- All CCGs will be working towards commissioning a common bundle of services that will be provided by individual practices or by groups of practices across localities or networks. CCG will aim to commission services using a service specification and pricing structure agreed across the five CCGs. CCGs will be working together to fund the required investment in primary care. The out of hospital framework will be used to support this process

- While we will seek to standardise as far as possible, we recognise that different CCGs have populations with differing needs. Therefore, where appropriate, there may be some local variation in the out of hospital services commissioned by individual CCGs.

- We expect to compete some services that are currently commissioned using LES contracting mechanism. However we expect the list to be limited.

The CCGs will look to commission services from all providers of general medical services but will work with NHS England to ensure that there is no duplication of service or payment in relation to PMS or APMS providers who deliver services above and beyond the requirements of the general medical services contract.

The CCGs will aim to move to this commissioning arrangement as early as possible in 2014/2015. In order to ensure continuity of service provision the CCGs will transfer services currently commissioned as enhanced services on to standard NHS Contracts with effect from 1.4.14.

The above intentions and table below are subject to further assessment and testing by CCGs and the CCGs may amend these as further work is undertaken. The table below is an initial assessment of the groupings that services might fall into and where initial assessments indicate that General Practice may be the most capable provider. The draft Out of Hospital Framework will be used to further test this.

The CCG will either continue services but under new NHS contracts or it will evolve them. Services to be continued include those which have recently been introduced and need sufficient time to demonstrate effectiveness.

Services to be continued:

- The 7 Day Access
- Co-ordinate my care
- Learning Disabilities
- Psychological therapy in primary care
- Homeless Outreach

Services to be evolved:

- Oral Anti-coagulation
- Phlebotomy
- Information Management and Technology
- Choose and Book
- The Locality Plan
- Extended Opening Hours
- Minor Surgery
- Care for the Homeless
- Complementary Therapies

CCGs will write to practices outlining those services that they will be decommissioning and those services that they will continue to commission in 14/15 but on an NHS Standard Contract whilst specifications are reviewed and services procured. The letter will also indicate which services are likely to be procured for delivery at the start of 14/15. Practices can expect to receive this letter by the middle of December.

| 1.0 CLINICAL | EXAMPLE SERVICES | RATIONALE | Initial Assessment of Commissioning Route |
|---|---|---|---|
| 1.1 Enhancement of existing core service provided by General Practices | Care planning / care management<br><br>Enhanced access to routine primary care<br><br>Co-ordinate my Care<br><br>Post operative wound care<br><br>Ambulatory blood pressure monitoring | In line with whole systems strategy that puts GPs at the centre of coordinating patients' care<br><br>Requires clarity of accountability (which remains with GP Practice) or are list based services<br><br>Service will need to be integrated with existing care / provide continuity along a pathway | Signal in commissioning intentions that we expect to commission these services from individual practices and will look for 100% coverage from General Practice. Individual Practices may subcontract to other General Practices to enable CCG to get to deliver equity of access. |
| 1.2 Additional service – provider will need to demonstrate capability. Continuity of care and integration of service provision are seen as critical | 7 day access to routine primary care<br><br>Mental health – primary care plus services<br><br>Enhanced management of patients with long term conditions:<br>• Anti-coagulation services for stable patients<br>• Insulin initiation<br>• Methotrexate prescribing<br>• Services for homeless patients<br><br>Violent patients | Service will need to be integrated with existing care / provide continuity along a pathway<br><br>Requires clarity of accountability (which remains with GP Practice)<br><br>To provide best quality the service may need to make best use of scarce skills to serve a network of GP practices<br><br>Or<br><br>Service could give patients choice of provider<br><br>Service providers will need to utilise SystmOne, the shared patient record | Signal in commissioning intentions that CCGs expect to commission services across networks. CCGs will look to award to "lead" practices who can deliver services on behalf of patients within their network.<br><br>To get coverage across networks sub-contracting across networks would be allowed |

| | | | |
|---|---|---|---|
| 1.3 Additional service – multiple providers possible but location of service provision seen as important to ensure continuity of patient care | Service best provided from within practice buildings unless VFM or other considerations make this impossible, at which point competition of providers may be sought.<br>Phlebotomy<br><br>Near patient testing<br><br>Counselling | Service will need to be integrated with existing care / provide continuity along a pathway<br><br>Wider holistic benefits can be gained by providing services in a setting where the patient is also receiving other aspects of care at the same time<br><br>Requirement for multiple locations reduces opportunity for VFM being achieved through a procurement and increases the administration costs associated with managing contracts | Signal in commissioning intentions that CCGs expect to commission services from individual practices.<br><br>Where practices decline to provide service, procurement or sub-contracting across networks would be sought to ensure services are provided for all patients |
| 1.4 Additional service – provider will need to demonstrate enhanced skills requiring further training / accreditation | Any Capable Provider<br>Minor surgery<br><br>Joint injections<br><br>Psychological therapy in primary care (IAPT)<br><br>Homeless nurse outreach | Already other providers in the market and generally not provided by general practice itself | Signal in commissioning intentions that the Contracts will be completed during 2014 but in the short term contracts may be migrated over to NHS Contracts as a holding position |

### 3.4.2 Other Primary Care

We will review our plans for primary care against emerging national guidance, including the likely additions to the NHS Mandate covering named GPs for older people, care planning and out of hours primary care

*Some overarching principles are:*

- Linking services so we build functioning integrated services with GPs at the heart
- Implementing and getting the most out of the GP single clinical IT system is crucial

*Intentions for 2014/15*

- Prescribing – achievement of c£1m reduction in prescribing costs for each CCG
- Out of hours service – review of current arrangements with view to bringing into localities
- Core GP – agree standards that all GPs to work to as part of NWL primary care transformation programme and remunerate appropriately.
- Increase access to and patient outcomes of primary care based mental health counselling and therapeutic support. Ensure that patients continue to receive appropriate support to keep them out of hospital and receive personalised care plans to keep them well. This will include supporting the Wellwatch programme to reduce non elective admissions, risk stratify and identify suitable patients.
- On-going development of new services in primary care such as DVT testing, Hepatitis C testing and treatment for homeless patients. We are also establishing joint working in general practice with Consultant Paediatricians, all with a view to reducing inappropriate hospital attendance.

A summary of the current and potential future projects for this area are summarised in appendix 2.

### 3.5 Nursing & Residential Care – Joint Intentions

Tri-borough CCGs are committed to ensuring that members of our community who live in residential and nursing homes have the highest quality of care and support. This will become more and more important as demographic changes mean greater demand for these services.

We have a shared ambition for our nursing and residential provision:

- More people supported to live independently for longer and delayed in going into institutionalised care;
- When institutional care is required, more appropriate placements in high quality care settings which exceed Care Quality Commission standards;
- More people living longer with reduced isolation, falls and unplanned hospital admissions;
- More clients and their families involved in and happy with the placements made.

*Improving our commissioning*

The improvement of Tri-borough commissioning of nursing and residential care for all residents of Kensington and Chelsea, Hammersmith and Fulham and Westminster will be delivered through a joint commissioning team.

As we continue to drive improvements in quality and efficiency across the nursing homes and residential homes in our area, we are also making sure that our own commissioning infrastructure is fit for purpose. Therefore we are re-structuring the way in which we commission services, reducing duplication in the commissioning, quality and review mechanisms, administration, monitoring and assessment of placements.

A single commissioning team will facilitate improved interfaces with other inter-related services such as the Community Independence service, GP services to care home and the London Ambulance Service.

This will ensure that wherever possible people are supported people in their homes and communities, with reablement, independence, wellbeing and social inclusion and initiatives such as supported living, care packages in people's homes and extra care housing.

A single commissioning team across health and social care will ensure greater consistency of approach in commissioning and contracting practice which should drive up quality and choice, and enable greater transparency on costs and outcomes:

- Consistency of contracting
- Robust single approach to monitoring quality, outcomes and use of resources
- Comprehensive approach to safeguarding

*Measuring the impact*

Managing and improving performance is one of the key drivers for our restructure. We also need to monitor the impact of these changes within our own organisations and will be looking at a number of KPIs including:

- Reduction in contract expenditure – benchmarked against other London Boroughs
- Reduction in spot placements
- Increase in client and resident satisfaction
- Increase number of block placements available and the number of providers who provide block placements.

A summary of the current and potential future projects for this area are summarised in appendix 2.

**3.6 Planned Care – CCG Intentions**

Our aspiration is to increase the proportion of care that is planned but also simplify the existing pathways with more of the diagnostics and decision making carried out in community settings.

CCGs within CWHHE will be reviewing and developing planned care pathways and community provision aligned to their own strategic priorities and population needs. The CCGs within CWHHE will work together to understand the models that are developed and will look to evaluate these locally and implement best practice wherever possible.

*Intentions for 2014/15:*

- Review all care pathways with a view to understanding what conditions primary care physicians can manage and what consultants can manage. We will explore the potential to up-skill primary care to deliver planned care more effectively in this context
- Consider how we can encourage the development of more primary care based community services where these meet quality standards and represent value for money
- Consider the business case for enhanced primary care across several key pathways. These are:
    - Diabetes: including more easily accessible and simpler structured education programmes, the potential for insulin initiation and enhanced annual checks, the potential for accreditation/minimum competency requirements for providing services beyond the basic level, development of a pre-diabetes register, and specialist services
    - MSK: In previous years, the five CCGs in CWHHE have independently commissioned their community MSK provision resulting in a range of different services for orthopaedics, rheumatology and chronic pain management. There are many examples of good practice being implemented including, for example, simplifying the patient journey and delivering care in community settings closer to home to improve outcomes. A common QIPP goal of all the CCGs was to reduce referrals into acute orthopaedic services. Unfortunately the impact from the existing community based MSK services to date has been lower than expected.
    - Cardiology: management of heart failure has been identified as a system gap by many GPs. We will explore the potential for a community service to manage heart failure outside the hospital and to reduce admissions and outpatient referrals
    - End of Life Care (EOLC): including building on Co-ordinate My Care implementation, the implementation of any recommendations from the review of the Liverpool Care Pathway, and developing a more holistic approach to EOLC
    - Chronic kidney disease (CKD): we will continue to work will colleagues across NWL to review and improve the care pathway between primary and secondary care

- Support implementation of the diagnostic cloud. We expect to see electronic sharing of all pathology results generated across NW London by end of 14/15 with a plan to do the same for radiology results
- Agree with Imperial a diagnostic formulary for primary care
- Over the last few months, CWHHE CCGs have been working closely with Imperial to review improvements and transform planned care. This has been supported by the NHS IQ development programme. Outputs from the work that are emerging can be translated across all acute providers for CWHHE.
- Expected outcomes for accessing specialist advice are:

- maximizing the benefit of a Single Clinical System by increasing availability in out-patient, pre-assessment and rapid access clinic settings in secondary care
- realising a change in behaviour so that both primary and secondary care are working together to make savings for the health economy, make sure patients at treated in primary or community care when they can be. This could include
    - email / telephone consultation between the GP and consultant
    - consultant triage of referrals to ensure they get to the appropriate sub-specialist opinion
    - consultants undertaking clinics in primary care (e.g. proposed Community Paediatric hub model)
    - consultants inputting their decisions directly into GP IT systems

- reduce patients having to "pin-ball" around the system – when multiple and sequential appointments are required for referred condition (including diagnostics/ subspecialty transfers)
- increased and consistent availability of one-stop and or joint speciality clinic availability across a range of specialities
- increase communication and access between clinicians to help manage individual patient care management plans
- increased number of patients with joint care management plans and case management where appropriate
- system working with agreed and shared pathways / guidelines which clearly define the diagnostic requirements prior to first appointment and subject to regular clinical audit to review effectiveness or need for change to agreed pathways / specialities
- effective mechanisms across the system for the exchange of knowledge of services and pathways across community/secondary care to enable patients to be on correct pathway
- alternative to face: face consultations increasing availability of telephone consultations when clinically appropriate
- quantifying the expected activity defined as Internally generated – with KPIs and CQUINs aligned to support system transformation where appropriate
- using these outcome to support the development of localities/ hubs managing patient care
- Improving appointment booking processes - feedback from both patients and staff working within the system identified the need to:
- improve availability of routine and urgent appointments on choose and book
- review/ clinical triage of referral within Trust prior to first appointment to /from subspecialties as required
- receive and act upon communication from patients regarding appointment suitability / attendance and as a consequence review of DNA processes
- maximise the use of referral services for handling and managing (nearly) ALL referrals

The 14/15 actions will be for providers, the CSU and CCGs to deliver transformation by:

- Inviting providers to propose how they will assist with transformation of efficiencies within system - and suggest contract payment and incentive mechanisms for this
- All divisions, to sub-specialty level, to review the activity data identifying Internal pathways that lead to internally generated activity with a view to transforming pathways to joint clinics / one stop clinics / diagnostic results available at first appointment. This to be supported by regular clinical audit for impact.

- One-stop shop clinics – review of proportion of patients able to attend a one stop shop clinics, increasing availability and throughput – this should include vascular, urology, gynaecology, (and uro-gynae), gastroenterology, cardiology
- Pre- assessment clinic pathways - review diagnostic bundle availability at speciality level
- Review process for patients who do not meet surgical pre-assessment screening thresholds – develop protocol specifying actions required that are jointly agreed with the patient's GP and ensuring access to GP clinical records (via SystmOne)
- Develop pathways with direct access to specialist for urgent / emergency review to avoid A&E (working towards seven days a week) – with initial consideration focused on gynaecology / cardiovascular
- Develop and implement referral guidelines / pathways
- Ensure diagnostics availability consistent availability 7/7 and with increased access (towards 24/7) for acute wards
- For agreed conditions / diagnoses develop mechanism that enable patient moving straight to list from diagnostic
- Within the contract discussions for 14/15 the following will be discussed and agreed
    - incentivise providers to redirect to appropriate community service and include mechanism whereby payment will not be made if this has not been done
    - introduce a single charge for patients referred from A&E to other emergency OP based services e.g. early pregnancy unit
    - restrict referrals to other specialties made following an inpatient discharge to having agreement from GP
    - agree the specialities where all internal referrals (e.g. GUM) must to be returned to their GP/ Referral service; expectation is that some specialities will have zero internally generate referrals (IGR)
    - to quantify current IGR activity and targets for the 14/15 – 15/16 contracts
    - agree how CQUINS and KPIs can be used to enable system and avoid any unintended consequences / disincentives
    - where appropriate agree local tariffs – for example for one stop shops and telephone consultations
- Planned Procedures with a Threshold (PPwT) and Individual Funding Requests – Central London CCG, is aligned with the intentions developed across NWL on both these areas. The guidance has three main sections of commissioning intent:
    - Planned changes to existing PPwT Policies
    - New Policy Development
    - Changes to PPwT/IFR Governance Process.
    -

*Chronic obstructive pulmonary disease (COPD)*

There is good evidence that following best practice guidance avoids readmissions for acute episodes of COPD. Building on this evidence, the NWL CLAHRC has developed a secondary care bundle for COPD for patients discharged from hospital. The care bundle is already been used in several organisations in the sector but there is scope for higher and more systematic uptake. The adoption and diffusion of this care bundle has therefore been identified as one of the early priorities for Imperial College Health Partners, the local Academic Health Science Network which is jointly owned by providers and commissioners in NWL.

In order to support the sector wide take-up of the care bundle, CCGs will ensure that community pulmonary rehabilitation services across NWL are evidence based, sustainable, and accessible to patients exploiting synergies where possible. We will also work with Public

Health partners to ensure adequate provision of smoking cessation service provision. In return, we expect all relevant secondary care providers to implement and monitor the uptake of the secondary care bundle. Through ICHP, we will work collectively as a sector to remove barriers to the uptake and monitoring.

A summary of the current and potential future projects for this area are summarised in appendix 2.

**3.7 Cancer Commissioning – CCG Intentions**

Our priorities for cancer commissioning intentions cover these main areas:

- Early detection pathways and what we need to commission as a result
- Increased endoscopy investment to reflect bowel cancer screening extension
- Survivorship treatment planning
- Urology patients requiring only monitoring of PSA levels to be discharged from hospital with follow-up in primary care.

*The implementation of early detection best practice commissioning pathways*

Early detection pathways have been developed for lung, colorectal and ovarian cancer and these will be included, with the living with and beyond cancer pathway elements, in the revised best practice commissioning pathways. These will be included as service specifications within the 2014/15 contracts. The main recommendations are:

- Ovarian pathway:
    - Undertake both CA125 and trans-vaginal ultrasound concurrently
    - Ensure GPs consider referral along colorectal pathway
- Colorectal pathway:
    - Commission direct access to one stop diagnostic service in secondary care
    - Reduce the threshold age for referring new onset colorectal symptoms from 60 years of age in 2013-14 to 55 years of age in 2014-15 and 45 years of age in 2015
- Lung pathway:
    - All primary & secondary care staff trained in giving Very Brief Advice in smoking cessation
    - Develop excellent links with local stop smoking services
    - Ensure safety-netting processes in place to ensure patients, where appropriate, are recalled for chest X-ray
    - Whenever a chest X-ray takes place, ensure it is reported

*Increased endoscopy investment to reflect bowel cancer screening extension*

An evidence-based strategy is currently being developed to provide the case for each CCG, highlighting the difference between the level of services currently being commissioned and what is proposed for 2014/15 and beyond. The main recommendations are:

- Commission only from JAG accredited provider whether NHS or private
- Commission additional endoscopies as per the early detection best practice commissioning pathway for colorectal cancer
- Ensure surveillance approach for symptomatic patients means all patients are recalled appropriately with no patient at risk of falling through the gap

*Survivorship treatment planning*

The extension of the Recovery Package: the objective is to build on the work in 2013/14, by both increasing the percentage of people who are offered a Holistic Needs Assessment, Care Plan and Treatment Summary, plus also extending the Recovery Package to include a Health and well-being event.

In order to sustain recovery, planning is taking place associated with measures in the following areas:

- Physical activity
- Work and finance.

**Endoscopy**

Associated investment will be built into CCG'S investment plan for 14/15 once relevant figures have been finalised.

A summary of the current and potential future projects for this area are summarised in appendix 2.

### 3.8 Mental Health – Joint Intentions

Central London CCG, in partnership with other CCGs and local authorities across North West London, is committed to a significant transformation programme for mental health. We are developing a 3-5 year integrated plan for mental health with the Local Authority and our commissioning intentions for 2014/15 and beyond will be informed by this plan, which in turn will be framed by the NWL Mental Health Programme Board Strategy.

The CCG will focus on a fundamental shift to the settings of care in which people with mental health conditions can access support and treatment. General practice, supported by an integrated Primary Care Mental Health Service, will provide the foundation of excellent care and support for people with mental health needs and their families/carers. By April 2014 Central London CCG will have ensured that GPs are supported to develop the skills that they need in managing people with both common and severe and enduring mental illness. A single point of referral across Central London will be in place providing access to psychological therapy services. Community services will be reviewed and redesigned and the acute care pathway will ensure that patients can step into high intensity care and back down to supportive local services appropriately and speedily, when needed, with care delivered where patients want it, in and out of core working hours.

Patients and the public have told us that reducing stigma related to mental health in BME communities, as well as improving access to mental health services for these communities, should be one of our priorities for 2014/15. To address this, Central London CCG has mental health embedded within its Equality Objectives for 2013-2017. There will be a focus on improving mental health and well-being for BME communities and people with learning disabilities, and IAPT services will be reviewed to ensure that they are equitable for all groups, as outlined below.

*Our specific intentions for 2014/15 include:*

- Protecting mental well-being – we will work with public health and other departments such as regeneration (particularly in relation to employer engagement) and environment to develop an action-plan for interventions which promote mental well-being and resilience and which reduce stigma, including supporting national campaigns such as Time to Change.
- Access – full roll out of the operational standards, principles and procedures agreed across NWL (see Mental Health Access Policy for NWL, October 2013), including a single point of access/phone number per CCG area.
- Urgent Assessment & Care (Phase 1) – concrete progress through redesign by secondary providers towards (a) extension of daytime hours to better match those in primary care (8 am – 8pm); (b) a single point of access 24/7/365 for all GP advice and referrals and (c) increased home visiting 24/7/365 to resolve new crises in people's homes, reducing the need for patients to travel to A&E departments after daytime crisis/urgent assessment services close.
- Urgent Assessment & Care (Phase 2). The NWL Mental Health Programme Board will, as a London SCN Pathfinder, lead a systematic, multi-agency review of how urgent mental health assessment and care is commissioned, organised and delivered against national best practice and emerging NHS England expectations. Scoping work to take place October – March 2014, with actions identified during Q1 2014/15 and implementation taking place to year end.
- Liaison Psychiatry Services. In line with the NWL-wide review, a common specification and contracting of services in particular at the Chelsea & Westminster (with Central London CCG)

and St Mary's Hospital (with H&FCCG) to ensure equity of access, improved performance, consistent standards assurance reporting and a 'fair shares' approach that recognises usage by CCG and the financial cost saving benefits to acute hospitals through inappropriate emergency admission avoidance, medication review and length of stay minimisation for mental health patients.

- Community Service Transformation. As part of the CNWL-wide transformation programme, in partnership with all 5 commissioning CCGs, the CCG will be pursuing transformational change to the settings in which mental health service users are assessed and cared for. As part of this we will ensure the necessary systematic review of existing specialist community service pathways to baseline existing spend, activity, throughput, performance against key metrics, workforce and spend, by CCG. A key issue will be to ensure that issues of cross-border activity between CCGs are kept to a minimum to ensure equitable access across CCG areas and effective joint working between health and social care.
- Quality and Evidence Base in Mental Health – implementing Payment by Results for mental health. In line with NHSE and DH timetable, CCGs and Trusts will need to develop a clear work programme to review existing practice and standards against those published NICE guidelines associated with Care Clusters and PbR. We will also work with the Mental Health Trusts to ensure continuous improvement in compliance with statutory duties and the Mental Health Code of Practice. The review will span primary and secondary care, with recommendations for 2015/16.
- Whole Systems. Transformational change to the shape, scope and setting of community mental health service to models where they are increasingly delivered within multi-disciplinary services based in primary and community settings. This step change will be at the core of work to ensure parity of esteem between physical and mental health, securing increased delivery of these services side by side, in the least restrictive settings and at the point of demand rather than existing service location. Within this we will seek to ensure that those with mental health problems have improved physical healthcare, the mental health of those with long term conditions is proactively managed and also the promotion of self-management.
- A review of rehabilitation service provision and development of a forward commissioning strategy across the sector, with further re-patterning of Out of Area placements into local facilities.
- The Local Authority and CCG will also review mental health supported housing and floating support schemes to ensure good pathways that support recovery. We will review the needs of people in homelessness accommodation and single homeless supported housing to ensure their mental health needs are met effectively, especially in view of the impact of the Housing Benefit changes
- Implementation of year 2 of the shifting settings of care project to manage patients in primary care community settings rather than secondary care. We are currently undertaking work to identify the cohort of patients who can be supported in primary care and this will inform the numbers of patients who can be transferred. This programme will be implemented with service users and their carers to ensure that service change is co-produced and embedded to facilitate professional good practice and deliver a fundamentally different experience for those accessing care. A community contract will facilitate the discharge of patients to primary care provision.
- We will implement clear pathways for patients in secondary care and primary care to access paid employment, training, education, volunteering, positive social networks and other meaningful activity and ensure we have information systems in place to make sure everyone understands how they access this provision. We will consider supporting the development of social enterprises where this is a feasible business model.

- We will implement recommendations from the tri-borough mental health service user involvement review to ensure that we have systems in place for meaningful co-production and involvement in the new commissioning landscape and to reflect shifting settings of care.
- Dementia – we will develop a coherent plan across the CCG as part of the proposed Tri-borough Dementia Strategy with CCG and Local Authority partners to address variance in diagnosis rates and move towards the national 'benchmark' of 66%. Specifically, we will:
    - Develop the models of delivery offered and the treatment, care and support offered to all those who enter the dementia diagnostic and subsequent care pathway.
    - Work with social care partners to deliver an integrated approach to dementia care, including support for carers
    - Support the creation of dementia friendly-communities that support people with dementia and their carers to live well with dementia.
    - Commission good support for carers of people with dementia to allow them to remain healthy and independent.
    - Improve responses to people with dementia, pre-empt crisis and breakdown of care, and prevent avoidable hospital admissions by developing a community-based Assertive Response Dementia Home Treatment Team to provide rapid assessment, referral and signposting to appropriate services
    - Improve referral from primary care for dementia diagnosis by increasing assessment and diagnostic provision and care co-ordination
- We will improve physical rehabilitation for people with functional or organic mental health need to reduce length of stay and prevent avoidable readmissions to acute hospitals.
- IAPT – we will make targeted improvements to ensure we deliver the 15% national 'treatment penetration' ambition and increased recovery rates. In addition, the CCG will review IAPT services to ensure that they are equitable for all groups, with a particular focus on older people, young people, and people with long-term conditions, carers and BME communities. There will be a community contract in place to support the assessment of mental health needs and the appropriate referral for treatment.
- Measuring Outcomes, Testing Satisfaction, Assuring Quality, Delivering Value. Development and delivery of a rationalised set of required monthly dashboard indicators, including national requirements, outcomes, productivity and performance metrics, to support NWL-wide benchmarking. To be in place from April 2013 latest, for May reporting, and monthly thereafter.
- We will also work with the Local Authority to improve recording on Framework-I and to develop meaningful joint indicators which evidence the effectiveness of the mental health system in delivering good outcomes for people with mental health needs and their carers and families. Within this we will include improved monitoring of patient-reported experience and recovery and carer experience.
- We will implement recommendations from the review of dual diagnosis services taking place in RBKC and develop a business case for the best management of dual diagnosis services, which will include agreed pathways for people with both a mental health and substance misuse condition. In Hammersmith and Fulham and Westminster we will take learning from this review to inform service improvements locally.
- We will commence a programme of reviewing and developing protocols for working with people with mental health and other needs including people with learning disabilities and people in the criminal justice system and we will also review develop transitions protocols from CAMHs to adults and from adults into older people's services.
- We will work with the Local Authorities to deliver more personalised and flexible services that respond to individual needs and preferences.
- Following feedback from stakeholders, commence a review of the following areas of service provision to determine if there are gaps in services or the need for service improvement:

- Services for hoarders
- Parental mental health services
- Peri-natal mental health services

A summary of the current and potential future projects for this area are summarised in appendix 2.

**3.9 Learning Disabilities – Joint Intentions**

Our 2014/15 intentions are to:

- Ensure that the learning from the Winterbourne View Inquiry continues to be implemented which takes into consideration any gaps identified in the 2013/14 Learning Disabilities Safeguarding Self–Assessment Assurance Framework (SAAF)
- Work closely with the LA to review the quality and capacity of the community based support for learning disabled people
- Increase the percentage of learning disabilities patients who have had a GP annual review; this is one of the CCG'S Equality Objectives 2013-16 and there is an action plan in place to achieve this
- Continue to work with primary and secondary care to improve both access and experience of mainstream health services for people with learning disabilities
- Work with providers so that in-patient services take full account of the needs of the individual to ensure a timely and appropriate return to the community through the use of transitional arrangements
- Work in collaboration with other CCGs across NWL to improve the local services and response to people experiencing a mental health crisis.

### 3.10 Autism – Joint Intentions

The Autism Self-Assessment Framework identifies the need to consider the needs of older people with Autism. This will include diagnostic and assessment needs as well as specific services. This will be considered in line with the Tri-Borough Autism strategy.

The Autism Self-Assessment and Learning Disability Joint Strategic Needs Assessment identifies the need to offer post-diagnostic support. In addition, the Tri-Borough Autism Strategy and CWHHE equalities plan identifies the need for early intervention services to prevent people on the Autistic spectrum utilising the mental health pathway where this can be avoided by the use of community based services. There is an intention to commission an intervention project to support this.

**3.11 Children - Joint Intentions**

Children's health and development needs are a central focus for Central London CCG in 2014/15. There have been some fundamental changes imposed by the Health and Social Care Act 2012 to the commissioning landscape which encourages a new approach to integrated planning and provision for children and families. We know that children often use acute services when primary care or community responses may be just as effective, less disruptive for children and less expensive.

*Child Health General Practice Hub - Connecting Care for Children*

The Tri-borough will improve the way in which children are supported through implementing Connecting Care for Children's Health (CC4C). Building on the evolving locality based GP network structures; CC4C will increase community capacity to support children while also working with families and children to build their own resources and capabilities. Addressing both of this is central to achieving reductions in A&E attendances, outpatient attendances and acute-based procedures.

All of our relevant providers will build on locality activity already underway in CCGS, and relationships already established. Providers will develop value from the wealth of expertise already present within the local health economies. Rather than superimposing an additional or separate system, CC4C is intended to co-ordinate activity to:

- Bring current professional expertise and existing resources together to more effectively deliver care
- Build collegial relationships which facilitate the exchange of knowledge and skills
- Increase timely access to primary care for patients
- Enhance patient capacity to understand the local health and care system
- Build parent confidence in the local health and are system
- Improve peer to peer support, especially among young people with long-term conditions

At the heart of Connecting Care for Children's Health are three elements:

- Paediatric outreach – multi-professional case-based learning sets and joint outreach clinics to position the GP Surgery as the central point for integrated child health care
- Patient public capacity – recruiting, training and supporting a network of practice champions to lead patient engagement and co-production, enabling peer support and self-management, and ensuring that GPs, acute clinicians, and patients work together as standard
- Open access – supporting telephone and email consultation between GPs and paediatricians, and same day access for patients and GPs.

We will increase capacity in primary care and will achieve this through localities, with networks of practices covering at least 20,000 patients (approx. 4000 children). When fully operational the CC4C network will include primary care staff (e.g. practice nurses), acute partners, specialists and other local partners (e.g. early year's settings, early intervention, social care, schools, CAMHS etc).

Building collegial relationships within the locality and enhancing paediatric capacity in primary care through paediatric outreach are particularly important goals because evidence shows this can have a

significant positive impact on reducing demand on the acute sector. Evaluation of the Harrow Rd GP Based Educational Outreach Pre Pilot showed a 48% reduction in outpatient appointments, of which 20% were not seen by a paediatrician, but can be attributed to improved communication between GPs and the paediatrician, MDT discussion and enhanced GP capability. In addition the Harrow Rd pilot had a result of <2% DNA compared to average 20-25% DNA rate for general paediatric clinics in a hospital across North West London.

The precise members of a local CC4C will be flexible to enable adaptation of the core model to reflect locality, network or 'village' priorities.

The model will serve a spectrum of children, from the healthy child who requires good health promotion and advice, to the acutely mild to moderately unwell child.

Connecting Care for Children's Health represents a new model of care and requires new relationships. We therefore expect the provider to invest up front in developing the model with the local delivery partners and to set out a timescale and programme plan for achieving 40% rollout by the end of 14/15 and then 100% roll out by the end of 15/16 contracting round. We will ensure adequate resource is given to driving the change and to support localities in the development of their CC4C provision.

The Child Health General Practice Hub framework will deliver:

- Reduced use of unscheduled care, inpatient admissions and paediatric outpatient referrals via improved out of hospital care
- Improved awareness of families of services both in and around primary care
- Better outcomes for children, through coordinated care management; joint decision making; and treatment of children and young people within an outreach setting
- Development of the workforce, underpinned by enhanced paediatric skills, confidence and competence across the system, focused on primary care
- Better quality of care for children, closer to home, in a known and accessible environment, engendering confidence in the use of primary care
- Effective and apposite access to specialist paediatric skills in the context of primary care
- Financial savings across the system.

We will measure impact against all of the items listed above, as well as agreeing activity measures that need to sit underneath this.

We expect that each locality may have locally defined measures. However, in all areas we expect that there are measures against our agreed outcomes:

- Reduction in outpatient services of 20%
- Reducing A&E attendances of 10%
- Achieving a fall in admissions of 2%.

As a new approach that is being introduced simultaneously over a wide geographic area we expect a clear programme of monitoring, evaluation and learning from partners involved in the hubs. The

opportunity to learn from colleagues in other hubs in other CCGs is a valuable one for improving service design over time. Each hub will need to collect the same data.

The monitoring of operations will be reviewed locally by the network project team, comprising primary care, provider representatives and a practice champion. The development will be overseen by the Integrated Children's Services Board that will be established to lead on this work.

We will put in place the necessary levers to ensure that all providers are committed to and participating in the development and delivery of CC4C. This will be negotiated with each the provider based on the expected net savings to be gained from the Child Health General Practice Hub approach.

We expect acute providers will lead Connecting Care for Children, in close partnership with general practice and with support from Clinical Commissioning Groups. We will commission Connecting Care for Children through variance in the existing paediatric contracts. Just as CC4C does not introduce new services, but rather better links the existing wealth of expertise and resources, we are commissioning this by expecting reallocation of existing resources, rather than any injection of new funds.

*Other priorities for children's services*

During 2014/15, Central London CCG and the local authorities will:

- Increase emphasis on delivering midwifery in the community except for those with complex needs, linking it with GP shared cases more effectively. There will be a rigorous focus on performance reporting of the quality of user experience as well as caesarean sections, never events and consultant cover. We will contribute to the North West London maternity 'clinical strategy.' We will work with NHS England and the local Public Health team to ensure that the commissioning of antenatal and new-born screening programmes is appropriately integrated with the commissioning of maternity services. We will review the model and funding of perinatal mental health services.

- Plan for improvements in maternity care provision, linked with Shaping a Healthier Future, to ensure that every child has the best start in life.

- Work closely with social care and education partners in our local authorities to develop robust plans for delivering the new Children and Families Legislation (statute September 2014). This has particular emphasis on joining up services for children with special educational needs and disabilities (SEND) and requires local authorities and CCGs to develop a local SEN service offer; a joined up education, health and care (EHC) assessment and planning process; and personal budgets for EHC provision. This will include follow on work from the child development review (12/13) and include occupational therapy service developments and pathways for conditions (such as Autism Spectrum Disorders – see links below to CAMHS). We will consider tendering for a single occupational therapy service.

- Implement 'joint commissioning' for Speech and Language Therapy, including the development of key performance indicators and a new common service specification. We will strengthen user involvement and/or co-production.

- Develop a personal health budget offer for children eligible for continuing care, available from April 2014. This will put patients (children and parents) at the heart of decision making and help us to offer more child led, flexible and innovative solutions that improve outcomes for children with the most complex health needs and disabilities.

- Work with the lead commissioner of health visiting (NHS England) to ensure that local arrangements and service developments are addressed at a local level and any performance issues raised with NHS England. This will be underpinned by a Memorandum of Understanding with NHS England, setting out the joint arrangement. We will be supported in this work by the local Public Health team. We will work with the health visitor service to ensure effective joint working with general practice through the Connecting Care for Children model, supported by the use SystmOne (preferred GP clinical system of choice).

- Improve outcomes through Child and Adolescent Mental Health Services (CAMHS), including completing a review of Tier 2 and Targeted CAMHS. Alongside this there will be a review of both CAMHs On Call and CAMHS psychiatric liaison and the implication of this on tier 3. There also needs to be work done around firming up pathways for children with Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder to ensure good shared care.

- Integrate the Re-think patient experience work into service re-design plans. Implement an improved performance framework and service specification with CNWL.

- Deliver with Tri-borough and Public Health colleagues a clear business case for child and adolescent drug and alcohol services across West London CCG, Hammersmith and Fulham CCG and Central London CCG.

- Work with NHS England and the local Public Health team to ensure that immunisation programmes and Family Nurse Partnership services work to their best effectiveness.

- Commission high quality services for Looked After Children (LAC):
    - We will review the quality and capacity of the health services locally and identify the most effective way of ensuring that LAC placed outside of the borough receive the appropriate services.
    - We will strengthen the role of the designated doctor and nurse for LAC, ensuring these roles provide sufficient leadership for LAC across the health economy.
- Review 'designated' roles in safeguarding, Looked After Children nurses and Child and Adolescent Mental Health Services support to ensure compliance with new structures and efficiency requirements.

- Work with Public Health to ensure that the health and well-being priority of achieving healthy weights in children is embedded

A summary of the current and potential future projects for this area are summarised in appendix 2.

**3.12 Carers – Joint Intentions**

The CCG will continue to invest in services for carers, building on the work done in 2013/14, which has included the development of personal budgets for carers and for young carers. As part of its Equality Objectives for 2013-2017, the CCG will improve the rates of identification and support provided to carers and young carers, including within a primary care setting, and seek to offer appropriate support. The CCG will develop its plans in line with the intentions in the draft Care and Support Bill, which outlines the need to provide support services to carers, rather than simply identifying their needs.

Some principles around support to carers include:

- The need to avoid carers telling their story repeatedly and ensuring continuity in support
- Developing a consistent definition of 'carer' across health and social care and the need for information sharing across partners
- Raising awareness of the needs of carers across pathways, programmes and services – not just considering them at a point in time
- Recognising the needs of carers across our all our commissioning decision making processes.

Intentions for 2014/15

We will continue to maintain our investment in supporting carers, with support to young carers a key priority. We recognise the importance of working closely with partners and with organisations beyond health and social care, including education, in order to continue identifying and supporting carers.

Our specific intentions are to:

- Prioritise the identification young carers and the support for them. We will work with our LA colleagues, including education colleagues, on this. Specifically, we will develop a home-based family support service to support young carers
- Ensure/maintain appropriate registers for carers, e.g. GP registers, and explore cross referencing registers to proactively look for young carers
- Introduce Young Carers Personal Budgets with a new Tri-borough young carers provider
- Develop schemes to identify carers to health, social care and other professionals – to prevent them 'repeating their story' e.g. a 'carer's card'
- Provide training for carers
- Consider developing a GP incentive schemes to identify carers, e.g. baseline 5% increase per year
- Review the lessons from the primary care navigator role:
    - GP action plans to continue post-pilot
    - Understand how the learning can be applied to supporting carers in the virtual ward model of care, district nursing and other community settings
- Explore how we can address parking and transport issues for carers.

Measures of success in services for carers will include:

- Increased number of young carers identified through school education
- Increased numbers of young carers accessing support
- Identification & refer (signpost) systems embedded in pilot practices
- Completion of awareness raising training - e-learning by professionals

- Increased number of schools linked in with support services.

A summary of the current and potential future projects for this area are summarised in appendix 2.

### 3.13 Public Health – Local Authority Intentions

The Tri-borough Public Health team provides support and advice and commissions a range of services. The functions of the service are set out in the table below:

| **Prescribed Functions (Mandated)** | |
|---|---|
| Sexual health services – STI testing and treatment | Local authority role in health protection |
| Sexual health services – contraception | Public Health advice |
| NHS Health Check programme | National Child Measurement programme |
| **Non- Prescribed Functions (Discretionary)** | |
| Sexual health services – advice, prevention and promotion | Alcohol misuse – adults |
| Obesity – adults | Substance misuse (drugs and alcohol) – youth services |
| Obesity – children | Stop smoking services and interventions |
| Physical activity – adults | Wider tobacco control |
| Physical activity – children | Children 5 – 19 Public Health programmes |
| Drug misuse – adults | |
| **Miscellaneous Functions** | |
| Non-mandatory elements of the NHS Health Check programme | Local authority role in surveillance and control of infectious diseases |
| Nutrition initiatives | Information and Intelligence |
| Health at Work | Public Health spend on environmental hazards protection |
| Programmes to prevent accidents | Local initiatives to reduce excess deaths from seasonal mortality |
| Public mental health | Population level interventions to reduce and prevent birth defects (support role) |
| General prevention activities | Wider determinants |
| Community safety, violence prevention & social exclusion | Fluoridation |
| Dental Public Health | |

The Public Health team will extend some contracts in 2014/15 in line with its procurement timetable.

In line with this plan, Public Health are in the process of re-commissioning the following services:

- Stop Smoking Quits and Prevention
- Reducing reoffending
- Reducing reoffending in women
- SMS Group Work
- SMS Primary Care Support
- Club Drugs Project

In 2014/5 the team intends to review, commission or re-commission the following services:

- Childhood Obesity
- Young People Sexual Health
- Third Sector: Market Development
- Domestic Violence
- GUM Services
- HIV Services
- Core Alcohol Programme
- Core Drugs Programme
- Community Sexual Health & Reproductive Health
- Third Sector: Health Improvement for Specific Population Groups
- School Nursing
- Healthy Schools Partnership
- Detox Framework
- Cardiovascular Disease Prevention
- Peer Led Programme
- Health Improvement & Exercise Referral programme

## 4. Provider impact analysis

The purpose of this section is to flag for providers the scale of change associated with our commissioning intentions and the provider sectors where we expect the changes to impact.

The figures shown are indicative and more work to finalise them will be undertaken over the next few weeks.

| Plans by workstream | | | | |
|---|---|---|---|---|
| Workstream | Local Scheme Name | Gross Opportunity | Reprovision | Net Impact |
| **Integrated Care (Whole Systems)** | Wellwatch | (400) | | (400) |
| | Average length of stay (Excess bed days) | (200) | | (200) |
| | Respiratory - impact of community service | (150) | | (150) |
| | Urology - impact of community service | (54) | | (54) |
| | Integrated Health & Social Care Redesign | (1,200) | | (1,200) |
| | **Sub Total** | **(2,004)** | | **(2,004)** |
| **Community Services** | Community Provider Contract Efficiency | (850) | | (850) |
| | **Sub Total** | **(850)** | | **(850)** |
| **Primary Care** | Suspected DVT Community Pathway | (513) | 166 | (347) |
| | | **(513)** | **166** | **(347)** |
| **Mental Health** | Deliver efficiencies from Mental Health contract with CNWL | (913) | | (913) |
| | Primary Care Plus | (1,279) | 848 | (431) |
| | **Sub Total** | **(2,192)** | **848** | **(1,344)** |
| **End of Life** | End of Life | (400) | 120 | (280) |
| | **Sub Total** | **(400)** | **120** | **(280)** |
| **Emergency Care** | A&E improvements | (350) | | (350) |
| | **Sub Total** | **(350)** | | **(350)** |
| **Medicines Management** | Prescribing Opportunities | (1,000) | | (1,000) |
| | **Sub Total** | **(1,000)** | | **(1,000)** |
| **Continuing Care** | SHSOP Care Service Provider (CSP) Procurement | (185) | | (185) |
| | Consolidation of contracts | (300) | | (300) |
| | **Sub Total** | **(485)** | | **(485)** |
| **Acute Care** | Acute contract efficiencies | (2,028) | | (2,028) |
| | **Sub Total** | **(2,028)** | | **(2,028)** |
| **Planned Care** | Referral Standardisation | (300) | | (300) |
| | Respiratory | (190) | 133 | (57) |
| | MSK | (318) | 223 | (95) |
| | Gynaecology | (336) | 235 | (101) |
| | Ophthalmology | (272) | 190 | (82) |
| | Urology | (148) | 103 | (45) |
| | Diabetes | (113) | 79 | (34) |
| | Cardiology | (200) | | (200) |
| | Diagnostic Cloud | (157) | 117 | (40) |
| | **Sub Total** | **(2,034)** | **1,080** | **(954)** |
| **Grand Total** | | **(11,856)** | **2,214** | **(9,642)** |

| | |
|---|---|
| **QIPP Target** | **(9,638)** |

**2014-15 Provider QIPP Impact Analysis**

| CI Ref | Commissioning Intention | **Gross Savings (£000)** | Primary Care | Community (CLCH) | Mental Health (CNWL) | Acute (Imperial) | Acute (ChelWest) | Acute (UCLH) | Acute (Guys) | Residential & Continuing Care | Voluntary Sector | **Investment (£000)** | Primary Care | Community | Mental Health | Acute | **Net Savings (£000)** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **3.3** | **Emergency Care** | £2,754 | | | | £1,397 | £574 | £404 | £379 | | | £120 | + | | | | £2,634 |
| | **Integrated care (whole systems)** | £2,004 | | | | £1,017 | £418 | £294 | £276 | | | | | | | | £2,004 |
| | **End of Life** | £400 | | | | £203 | £83 | £59 | £55 | | | £120 | + | | | | £280 |
| | **A&E improvements** | £350 | | | | £178 | £73 | £51 | £48 | | | | | | | | £350 |
| | **Acute efficiency** | £2,028 | | | | £1,029 | £422 | £297 | £279 | | | | | | | | £2,028 |
| **3.5** | **Continuing Care** | £185 | | | | | | | | £185 | | | | | | | £185 |
| **3.6** | **Planned Care** | £2,034 | | | | £1,032 | £424 | £298 | £280 | | | £1,080 | + | | | | £954 |
| | **Referral Standardisation** | £300 | | | | £152 | £63 | £44 | £41 | | | | | | | | £300 |
| | **Respiratory** | £190 | | | | £97 | £40 | £28 | £26 | | | £133 | + | + | | + | |
| | **MSK** | £318 | | | | £161 | £66 | £47 | £44 | | | £223 | + | + | | + | |
| | **Gynaecology** | £336 | | | | £171 | £70 | £49 | £46 | | | £235 | + | + | | + | |
| | **Ophthalmology** | £272 | | | | £138 | £57 | £40 | £37 | | | £190 | + | + | | + | |
| | **Urology** | £148 | | | | £75 | £31 | £22 | £20 | | | £103 | + | + | | + | |
| | **Diabetes** | £113 | | | | £57 | £24 | £17 | £16 | | | £79 | + | + | | + | |
| | **Cardiology** | £200 | | | | £101 | £42 | £29 | £28 | | | | + | + | | + | |
| | **Diagnostic Cloud** | £157 | | | | £80 | £33 | £23 | £22 | | | £117 | + | | | | £40 |
| **3.4** | **Primary Care** | £1,513 | £1,513 | | | | | | | | | £166 | + | | | | £1,347 |
| | **Prescribing** | £1,000 | £1,000 | | | | | | | | | | | | | | £1,000 |
| | **Suspected DVT Community Pathway** | £513 | £513 | | | | | | | | | £166 | + | | | | £347 |
| **3.1** | **Community Services** | £850 | | £850 | | | | | | | | | | | | | £850 |
| **3.8** | **Mental Health Services** | £2,192 | | | £2,192 | | | | | | | £848 | + | | + | | £1,344 |
| **3.5** | **Consolidation of small contracts** | £300 | | | | | | | | £300 | | | | | | | £300 |
| | **Total** | **£11,856** | **£1,513** | **£850** | **£2,192** | **£3,459** | **£1,420** | **£999** | **£938** | **£485** | **£0** | **£2,214** | | | | | **£9,642** |

**5. Procurement intentions**

The purpose of this section is to highlight for providers those service areas where we intend to undertake procurements for services. This includes both existing services where current contracts are due to expire, and new investment areas where we anticipate that we can best deliver improvements for patients through an open procurement. The service areas and indicative timings for when the procurement process will commence are shown below. We are publishing this list to enable providers to best respond to our commissioning intentions but reserve the right to add or remove services or amend timetables should this be in the best interests of patients.

| Service area | Indicative annual value £000s | Indicative procurement commencement date |
|---|---|---|
| AQP Audiology | TBC | Qtr 4 2014/15 |
| Interpreting service | 15 | Qtr 1 2014/15 |
| Sexual Health HIV/AIDS - Mildmay Mission | 50 | Qtr 1 2014/15 |
| Community MSK | 1,595 | Qtr 1 2014/15 |
| DESTA (Expert Patient Programme) – Tri-borough contract | 338 | Qtr 1 2014/15 |
| Community Gynaecology | 235 | Qtr 1 2014/15 |
| BME Health Forum (Tri-borough service) | 68 | Qtr 1 2014/15 |
| Sexual Health HIV/AIDS | 77 | Qtr 1 2014/15 |
| Out of Hospital | 1,400 | Qtr 2 2014/15 |
| Community Dermatology | 235 | Qtr 1 2014/15 |
| Basic Foot Care | 220 | Qtr 1 2014/15 |
| Community Respiratory | 348 | Qtr 1 2014/15 |
| Provision of Wheelchairs including maintenance and repair | 253 | Qtr 1 2014/15 |
| Diabetes | 1,041 | Qtr 2 2014/15 |
| Mental Health Employment | 107 | Qtr 1 2014/15 |

| | | |
|---|---|---|
| Support | | |
| AQP IAPT services (CNWL) | TBC | Qtr 1 2014/15 |
| Community and primary care Patient Transport Service (Westway Travel Ltd) | 15 | Qtr 1 2014/15 |
| Diabetes User Group (tri-borough) (Independent facilitator) | 5 | Qtr 1 2014/15 |
| DVT services | TBC | Qtr 1 2014/15 |
| Hepatitis C services | TBC | Qtr 1 2014/15 |
| Services previously provided as Locally Enhanced Services commissioned by the CCG | 2,002 | Qtr 1 2014/15 |
| GP Out of hours | TBC | Qtr 2 2014/15 |
| Recomissioning of Enhanced Services | TBC | |
| **New services** | | |
| Community Ophthalmology | 380 | Qtr 2 2014/15 |
| Community Urology | 206 | Qtr 2 2014/15 |

| | | |
|---|---|---|
| NHS 111 | TBC | TBC |
| Re-commissioning of Enhanced Services** | TBC | TBC |

**6. Enablers**

We are investing in the following areas to enable the delivery of our commissioning intentions:

*Engagement with patients, carers and users*

As part of a collaborative-wide initiative, the CCG has been working with patients and wider stakeholders to develop a patient experience strategy to inform decisions for commissioning compassionate, safe and effective care.

*Next steps for the CCG will be to:*

- Facilitate co-design workshops with providers, service users and patient and community groups to develop a patient experience framework that will enable commissioners and local providers (health and social care, including third sector) to capture, act on and evaluate the impact of patient experience:
- To work together with CCGs within the CWHHE Collaborative and invest resources
    - in ensuring that all Patient Experience data and community intelligence reflects the diversity of the local population and is collated, analysed and presented in a manner that is transparent and accessible to providers, patients, communities and the public.
    - in presenting back – through *'You said.. We did'* – to patients, partners and providers how their feedback influenced CCG decisions.

Our work on embedding equality into the commissioning of health services is underpinned by engagement with our staff, stakeholders. We believe that engagement with and drawing on the expertise of residents, patients, services providers and third sector organisations, is critical in shaping services that are of high quality, value for money and reflect the needs of our diverse populations.

The CCG is working to increase the number of Patient Participation Groups in GP practices to enhance patient participation at practice level, and will continue its representation at key stakeholder meetings. In addition, targeted work will be undertaken with groups who do not normally engage, including young people, people with learning disabilities, older people with dementia, the Somali community and migrant and refugee communities.

*People and organisational development*

The CCG has a strong track record in organisational and people development.

Our GP Localities meet monthly, and participate in an extensive programme of audit and peer to peer learning. They review referrals, influencing referral patterns and aligning them to commissioning issues and training needs. The CCG works with the Localities to support the delivery of QIPP, and the Localities ensure that our members have a sound understanding of commissioning and prescribing budgets and how they perform in comparison to other primary medical care service providers and CLSs.

In addition to this, the CCG has established Learning Forums. They are underpinned by joint learning and working, with a multi-professional and multi-provider membership discussing cases that benefit

from discussion to assist with problem solving and/or provide useful learning for others. Forum meetings cover education topics, service provision and skills training.

Development of our membership is also supported by co-opting clinical leads to take forward specific areas of work.

The Governing Body participates in regular development sessions, which cover all aspects of the CCG'S activity. The programme includes regular sessions on finance and QIPP, our Out of Hospital programme, planning future programmes, and development of the Governing Body and its roles. Similarly, the management team facilitates its own quarterly development sessions to take stock of progress and the CCG'S work forward.

We will invest resources to develop and deliver a programme of equality training and support to the Governing Body, staff and patient leaders to embed equality considerations into the CCG Commissioning Plans and assurance processes. We will embed equality in CCG business planning and in particular will undertake and publish Equality Analysis of CCG Commissioning Intentions.

*Information tools*

The CCG'S strategy will be to continue to extend the principle of one electronic patient record across all settings of care. This is in alignment with existing and anticipated IT strategies published by the Department of Health and its associated bodies. As well as the local IT strategy currently under development for the whole systems implementation within the framework of Shaping a Healthier Futures strategy.

The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care :

- Level 1 - There is access to and two way information exchange within a common clinical IT system and a shared record between the GP and the care provider.
- Level 2 - Where the above is not possible due to technical, operational or financial constraints that as a minimum, the respective IT systems in primary care and elsewhere are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards (or other common messaging standards) as defined by the Health and Social Care Information Centre (HSCIC).
- Level 3 - Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible particularly where patients are receiving care out of area.

The CCG will work towards the sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care community. It will seek to fully implement the recommendations of the Caldicott2 review around the sharing of patient records to provide integrated and seamless care. Specifically it will ensure that role based access control to electronic patient records in all settings of care is standard. Furthermore, it will facilitate a mechanism and appropriate forum to ensure the management and governance of data controllers in common once common patient records are in place.

The CCG will continue to have active participation in the NW London IT Forum of commissioning and provider organisations, working collaboratively across the whole health economy to implement an

integrated approach to IT systems and information flows across the health and social care community and alignment of commissioning plans with IT solutions and vice versa.

More specifically the CCG will continue working with CWHHE CCGs to implement a single IT system across GP practices and several directly commissioned services where appropriate. Current and future providers will be required to work within the frameworks and opportunities that a single IT system across primary care can offer. This will be translated into more granular service specifications, service improvement plans and/or CQUINs where relevant. The overriding objective is to improve standards of care facilitated by the accurate, timely and appropriate information exchange.

*The CCG will in addition focus on these areas:*

- Continue working to improve the timeliness and quality of information sent to or accessible by providers from GP practices via clinical IT systems and to ensure the most up to date, relevant and accurate information is always sent.
- Continue working with providers to enable safer and more efficient electronic methods of communication between them and primary care, building on the previous work and solutions around real-time information CQUINs
- Implementing the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London. Initially focused on pathology but extending to other diagnostic services. Ensuring that ordering tests and receiving results for primary care are almost exclusively done electronically. As well as ensuring that access to a comprehensive chronological patient diagnostic record is enabled and actively in use in different settings of care
- Work with social services to develop an interface between IT systems and more robust information exchange within common information governance frameworks. Principally that all providers use the NHS number as the unique identifier of the patient for all services in order to integrate records
- Informing and enabling patients to improve their understanding and access to their medical records and taking a proactive role in their own care through the use of technology solutions that will improve access to their own records and interaction with care providers. In effect, enabling self care planning tools and solutions where appropriate and particularly targeted at patients with long term conditions
- Developing tools for GP clinical IT systems to provide integrated systems and processes such as in common clinical templates, status alerts and searches that will highlight key patients requiring further attention. Providing a patient risk stratification tool within (rather than outside) GP clinical systems, integrating more closely with other IT systems where the patient may have a record.

In addition the CCG will seek to implement (or make better use of) during 2014/15 and the following years, strategic IT systems such as:

- Choose and Book and its replacement system e-Referrals
- Electronic prescribing system
- Coordinate my Care system

*Estates*

With the changes effective from 1st April 2013 the CCG does not own any estates assets. However, it is acknowledged that the delivery of high quality healthcare will require access to appropriate accommodation in locations which reflect the health needs of the population. Any changes to the estates profile in the locality must be driven by those health needs.

A key exercise for the CCG is to understand the existing estate and particularly to appreciate:

- The mapping of capacity to the local health needs of the population
- The functional suitability and flexibility of each property from which services for the local population are delivered
- Specific gaps in capacity to address the needs of the new service delivery models
- Opportunities for future developments to support primary care and the delivery of new service models, in particular the vision for out of hospital care.

The CCG will continue to develop its Estates Strategy, which will be driven by the service models in conjunction with CCGs within the CWHHE Collaborative to ensure consistency to underpin a sustainable estates solution for both out of hospital and broader primary care service delivery.

As part of Central London CCGs Out of Hospital strategy we have identified the need to make investment (together with NHS England) in our primary and community premises, this includes:

- A new Health and Wellbeing Centre in Church Street
- A new health facility in Fitzrovia
- A Primary Care hub on the St Mary's hospital site

*Governance and performance management through networks*

Formal contract monitoring and performance monitoring against Key Performance Indicators will be undertaken through our arrangements with the Commissioning Support Unit. Performance variance is reported formally at our monthly Finance and Performance Committee.

In addition we have a well-established Locality infrastructure. Our 3 Localities regularly undertake peer review of referrals and admissions. They also monitor referrals into community services in order to ensure these are being well utilised. The Localities are commissioning vehicles and have a role in standardising referrals in line with our activity projections. Performance information is provided on a monthly basis which checks actual activity against that forecast. Any significant variance is explored by the group and an action plan is put in place.

**7. Stakeholder engagement**

The Commissioning Intentions for 2014/15 have been developed based on feedback from various stakeholder groups, including patient and public groups, and out Local Authority colleagues Chelsea, and the CCG GP membership. A full list of meetings and forums attended will follow in the next iteration

*Approach for 2014/15*

The approach to planning in 2014/15 was guided by a number of principles:

- Clinically led with engagement from GPs, member practices and oversight from the Governing Body
- Patient and public involvement through the User Panel and other stakeholder groups

The following stakeholders to be involved throughout the process:

- Public
- GP practices (CCG members)
- Providers (Community / acute / voluntary etc.)
- CSU
- Local Authority
- NHS England
- CCG team
- Governing Body
- Sub committees
- Focus / user groups

A summary of the current and potential future projects for this area are summarised in appendix 2.

## 8. Conclusion

This document has set out the commissioning intentions for NHS Central London CCG. They are intended to drive major transformation across the services that we provide to ensure that patients receive higher quality, more integrated care with an enhanced patient experience. We expect providers to respond proactively to our intentions and to work with us to ensure our vision is realised.

**Appendix 1: Detailed provider impact analysis**

Detailed provider impact analysis will follow.

**Appendix 2: CCG Projects**

## Integrated care

| Integrated Care (Whole Systems) | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0006 | Wellwatch (2013/14) | A project that seeks to enable more patients with LTCs (within risk score 61-95%) to have a mutually agreed care plan (supported by their GP) with a view to improving / maintaining their health for longer. |
| CL0007 | Integrated Health & Social Care Redesign | A project to realign CLCH and Social Care to the CCG locality structure and truly integrate those teams with Wellwatch and Mental Health. |
| CL0026 | Rapid response service | A project to improve rapid response nursing care to prevent admissions. |
| CL0031 | Early supported discharge into well organised community care | A project to coordinated around the localities a focussed team to coordinate discharge from hospital. |
| CL0062 | Transport review (inc. implications of OOH Strategy) | A project that aims to increase attendance at appointments/reduce DNAs and to support greater engagement with GPs for more vulnerable patients that find public transport unsuitable. |
| CL0064 | Homeless Intermediate Care | A project that will set up an Intermediate care facility for the homeless that will have strong connections with Secondary care discharge teams. |
| New | Development of villages to include additional services | A project focussing on development of villages to include additional services - Implementation of pharmacy, environmental health, health visiting etc into village set up. |
| New | Development of villages to include voluntary sector involvement | A project focussing on the Development of villages to include voluntary sector involvement. |
| New | Community programmes | Partnership working with the MCC on community programmes to reduce unemployment, improve fitness and encourage healthy eating. |

## Planned care

| Planned Care | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0001 | Referral Standardisation (inc.PRS) | A project to reduce the number of inappropriate referrals to secondary care and maximise the number of patients who receive the right appointment |
| CL0005 | Direct Access Diagnostics | A project to reduce unnecessary diagnostic activity along with delivering better value for money within the diagnostics budget |
| CL0080 | Cancer | A project to improve quality in Cancer services |
| New | One stop shop for multiple LTC | A project to review if there is a service for patients to go and have all their LTCs assessed holistically rather than in isolation. |
| New | Complex families project | A project to review provision in CCG area for complex families. Identify gaps / opportunities to improve outcomes for this group across all organisations |
| **End of Life** | | |
| CL0009 | End of Life - Dying in preferred place of death | A project to encourage GP practices to sign up for and utilise Co-ordinate My Care to increase figures of patients dying in preferred place of death |
| New | Better coordination of EOL care services including supported discharge for EOL patients | A project to identify and implement a solution to support EOL patients to be discharged from hospital to their preferred place of death |
| **Acute Care** | | |
| CL0016 | Acute contract efficiencies | A project that aims to generate efficiencies from existing contractual arrangements |

## Emergency Care

| Emergency Care | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0010 | A&E improvements | A project to reduce attendances at A&E and drive an increase in patients seen at Urgent Care Centres (UCC) and GP practices that are open at the weekend |
| CL0067 | Homeless A&E Attendances | A project to identify ways to reduce A&E attendance by the homeless population |
| New | Rapid response service | A project to improve rapid response nursing care to prevent admissions. |
| New | CLCH & GP Practice collaborative working | GP practices and CLCH to support patients who frequently attend A&E (top 100) though collaborative working and case management |
| New | GP OOH review / alignment | A project to ensure the coordination of out of hours services |
| New | St Mary's Hospital UCC retender | A project to ensure the application of the Shaping a Healthier Future UCC specification |
| **Urgent Care** | | |
| New | Determine CCG out of hours strategy | A project to ensure the coordination of out of hours services |

## Primary Care

| Primary Care | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0003 | Inter-practice referrals | A project to support shifting settings of care, SAHF and the out of hospital strategy |
| CL0028 | Extending GP opening hours | A project that extends GP opening hours at a number of practices to reduce unnecessary A&E and urgent care attendances |
| CL0032 | Increasing productivity in primary care | A project to improve productivity and realise the benefits to re-invest in patient care |
| CL0037 | LES review | A project to review enhanced services in primary care to ensure the best investment for patient outcomes |
| CL0041 | Primary Care Sustainability Development | A project to support the reduction of the NHS' carbon footprint by 10% |
| CL0050 | Increasing identification of carers using primary care | Based on national figures, there are a large number of unidentified carers in our area who are not accessing sufficient care. People who choose to carry out this caring role should receive proper assessment to understand what is needed to help fulfil this role. This project will support GPs to identify and provide for this need through training. |
| CL0056 | LD awareness training for primary care (pilot) | A project that will enable easy read information to be available in at least 2 practices per locality |
| CL0087 | MMR Immunisation Improvement programme | A project to develop an MMR immunisation programme that increases the numbers of patients being vaccinated and keeps people healthy for longer |
| CL0088 | Suspected DVT Community Pathway | A project to provide suspected DVT pathways in primary and community services |
| New | Improve uptake of preventative medicine programmes: Chlamydia Screening & Immunisations | A project to Improve uptake of preventative medicine programmes: Chlamydia Screening & Immunisations by partnership working with NHS England and peer review via Localities |
| New | Improving health visiting provision | A project to improve health visiting provision in partnership with : Childrens Services and NHS England |
| New | Understanding our highest A&E attenders | A project to support individual patients who use A&E services regularly and identify suitable alternatives |
| New | DVT project+ with anti-coagulation as LES is currently being reviewed | A project to provide suspected DVT pathways in primary and community services |
| New | Improve uptake of preventative medicine programmes: Chlamydia Screening & Immunisations | A project to Improve uptake of preventative medicine programmes: Chlamydia Screening & Immunisations by partnership working with NHS England and peer review via Localities |
| New | Planned care | A project supporting planned care initiatives in primary care |
| New | STIs | A project to consider how the CCG can support the prevention and treatment of STIs as identified in the JSNA |
| **Estates** | | |
| CL0090 | Fitzrovia Practice Relocation and Improvement | A project that supports a review of new premises for the Fitzrovia Medical Centre |
| CL0091 | Church Street Health and Wellbeing Regeneration Project | A project focussed on improving the primary care estate to deliver our Out of Hospital strategy |
| CL0092 | Tollgate / Maida Vale Health and Wellbeing Regeneration Project | A project focussed on improving the primary care estate to deliver our Out of Hospital strategy |
| CL0093 | South Westminster Centre:- GP Maximisation and Utilisation | A project focussed on improving the primary care estate to deliver our Out of Hospital strategy |
| CL0094 | St Mary's Hospital Health and Wellbeing Hub | A project focussed on improving the primary care estate to deliver our Out of Hospital strategy |
| **Medicines management** | | |
| CL0011 | Prescribing Opportunities | A project to support a reduction in primary care spend on prescribing and support the best quality of prescribing practice |

## CCG Specific

| Children | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0019 | Paediatric Planned Care (Maternity Matters) | NHS Central London CCG will introduce a new CQUIN to ensure the quality of maternity services provided is not only maintained but is enhanced under the new funding arrangements. |
| CL0020 | Local Authority Children Services efficiency | Associated with after school activity at special schools |
| CL0053 | Young carers | A project that offers short term interventions of up to six months per family identifying health inequalities through, and the impact of, wider determinants of health |
| CL0086 | Children's services (community) | Our strategy identifies the need for Consultants and GPs to work in partnership within primary care. These arrangements need to be fully scoped however the CCG has an intention to link this work to the Integrated Care teams CL0007 using the same GP locality structure. |
| New | Children's Centre | Our strategy identifies the need for Consultants and GPs to work in partnership within primary care. These arrangements need to be fully scoped however the CCG has an intention to link this work to the Integrated Care teams CL0007 using the same GP locality structure. |
| New | Poverty in childhood | A project to consider how the CCG can support the health and wellbeing of children in poverty, working with our partners, as evidenced in the JSNA |
| New | Maternity | A project to consider how the CCG can support the health and wellbeing of expectant mothers, working with our partners, as evidenced in the Health and Wellbeing Strategy |

## CCG Specific cont.

| Effective Organisation | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0068 | Maximising Performance Premium measures | A project to advise and support practices in order to Quality Premium related key performance indicators |
| CL0089 | NHSCL 2014/15 Commissioning Plan | A project to write the NHSCL 2014/15 Commissioning Plan |
| **Patient Safety** | | |
| New | Violent crime | A project to consider how the CCG can support a reduction in violent crime, particularly the health and wellbeing aspects, working with our partners, as evidenced in the JSNA |

## Community

| Community Services | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0002 | Cardiology - transfer of care | A project that aims to deliver a more accessible, efficient, cost-effective cardiology service |
| CL0004 | Respiratory Service Redesign (COPD) | A project that forms a part of an overall integrated care approach to managing patients with long term conditions, working with health and social care professionals |
| CL0014 | Community service efficiencies | A project that aims to generate efficiencies from existing contractual arrangements |
| CL0034 | MSK Community service re-tender | A project to define the future of all community based musculoskeletal (MSK) services within Central London CCG and procure a new service model. |
| CL0035 | Dermatology community service re-tender | A project that project relates to the procurement of a new community dermatology service |
| CL0036 | Gynaecology community service re-design | A project that relates to the procurement of a new community gynaecology service |
| CL0066 | Homeless Community Hepatology Clinic | A project that relates to the implementation of a consultant lead community scheme based in Homeless GP practices and the South Westminster Centre |
| CL0069 | Direct Access Diagnostics end of contract | A project that will explore alternative provision and models of delivery for Direct Access Diagnostics |
| CL0070 | Cardiology end of contract | A project to implement a Community Cardiology Service which will reduce the CVD contribution to health inequalities, reduce overall mortality attributable to CVD and deliver a significant increase in the level of activity carried out in the community thereby reducing the need for first attendances and subsequent follow ups within an acute setting |
| CL0085 | Basic foot care re-tender | A project that seeks to review the existing basic foot care re-tender delivery model to ensure it meets the needs of the local population, with a view to completing a procurement exercise for a replacement service. |
| New | Hep C project+, HIV etc | A project to consider combining the new HepC service with other testing and treatment for homeless people such as HIV etc. |
| New | Community Ophthalmology ***(Ophthalmology service)*** | A project to consider options for service and pathway redesign in local eye care services for a number of conditions including Wet Age-related Macular Degeneration (AMD) Rapid Access Referral, dry eye, Cataracts, Red Eye, and glaucoma screening |
| New | Community Diabetes | A project to consider the need for effective management of chronic long term conditions including diabetes |
| New | Community Urology | A project to consider options for urology service and pathway redesign in a community setting as a viable alternative to acute care |
| New | Ophthalmology service to include optometrists | A project to consider extending the scope of Ophthalmology provision to include optometrists |
| New | Childhood obesity and sensible eating | A project to consider tackling childhood obesity by targeted publicity campaign and ensuring consistent messages being given out from all related health care professions |
| New | Specialist drug monitoring services | A project to consider a community monitoring service for patients with chronic conditions taking red list drugs such as methotrexate and drugs which require careful three monthly/regular monitoring |
| New | Micro-suction unit for ears | A project to consider a service for patients who need to have wax removed from their ears. |
| New | Community headache clinic | A project to consider a service that would provide weekly headache clinics in each of the three localities run by a neurologist with the aim of reducing the number of inappropriate MRI scans. |
| New | To review best practice for direct access colonoscopy and breast screening clinics, | A project to consider the opportunity to implement some surgical specialities as well as medical ones for delivery of the OOH strategy. |
| New | A review of CLCH service provision | A project to review the scope of CLCH service provision |
| New | Drug misuse | A project to consider drug misuse (as highlighted in the JSNA) |
| **Continuing Care** | | |
| CL0012 | SHSOP Care Service Provider (CSP) Procurement | A project to support the Strategic Housing Services for Older People procurement with our partners |
| New | Reduction in non electives from care homes | A project to identify bespoke proactive nursing support for care homes to minimise the need for urgent care services - similar to the homeless nursing outreach |
| New | Improving post-stroke care and the dementia pathway | A project to improve post-stroke care and the dementia pathway |

**Community cont.**

| Continuing Care | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| New | Intermediate care and rehab - reduce admissions and LOS | A project to improve intermediate care and rehabilitation |
| New | Reduction in number of adults with autism entering mental health pathways inappropriately | A project to consider reducing the number of adults with autism entering mental health pathways inappropriately |
| New | Autism awareness training for primary care staff | A project to consider autism awareness training for primary care staff |
| New | Early identification of children who are likely to use ATU services working across WCC 5 universal providers | A project to consider early identification of children who are likely to use ATU services working across WCC 5 universal providers |
| New | Increase rate of GP health checks for LD patients to in excess of 80% | A project to consider increasing the rate of GP health checks for LD patients to in excess of 80% |
| New | Review community opportunities for adults who would use ATU services | A project to consider reviewing community opportunities for adults who would use ATU services |
| New | Dementia awareness training | A project to consider commissioning a series of dementia awareness sessions, possibly with council, to target different groups such as patients, practices, health care providers and the general public. |
| **Vulnerable Adults** | | |
| New | Review ICP programme of multi disciplinary teams in nursing homes | A project to consider review ICP programme of multi disciplinary teams in nursing homes |
| New | Implement medical cover for nursing homes | A project to consider the implementation of medical cover for nursing homes |
| New | Alcohol | A project to consider how the CCG can support the health and wellbeing for alcohol related illness, working with our partners, as evidenced in the Health and Wellbeing Strategy |
| New | Become a dementia friendly borough | A project to consider becoming a dementia friendly borough, in line with health and wellbeing strategy. |

## Engagement

| Engagement, Empowerment and Equality | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0045 | Behavioural change (Hard to reach groups / Communications / Children) | A project to understand the behavioural change needed in patients and the population and how the CCG can implement changes to support this. |
| CL0048 | Unscheduled care insight project | The project will award smaller grants to five local community organisations to carry out the insight work, driven by a questionnaire which will be created with the five local organisations, the BME Health Forum and NHS Central London CCG. |
| CL0049 | Carers training | A project to deliver a number of training programmes for new carers |
| CL0051 | Carers peer support network | A project to ensure carers feel better supported and are able to increase their wellbeing |
| CL0055 | Behavioural change scoping exercise | A project to provide initial engagement and research in order to define a strategic approach to changing the way in which patients engage with services |
| CL0057 | User panel leadership training | A project to deliver a series of training sessions driven by the needs of the User Panel to help them in achieving our statutory and aspirational engagement objectives |
| CL0058 | Patient training | A project to a series of training sessions aimed at patients, carers and service users to better support these target audiences in engaging with the CCG in its commissioning role |
| CL0059 | Interpreting services scoping and evaluation | A project that proposes to undertake a joint community / CCG led project to review the use of interpreting services in the borough, in addition to English class provision |
| CL0060 | CCG forum management | A project to deliver a series of forums to support engagement and delivery of the CCGs objectives, in particular those forming the Out of Hospital Strategy |
| CL0061 | Easy read | A project to increase the amount of information available to people with learning disabilities and people for whom English is not their first language |
| New | Youth health champions | A project to consider working with local young people, schools and organisations to identify and train young people to be health champions and engage their peers in local health and wellbeing |
| New | Linking patient leads and service user groups | A project to consider creating a way to bring together patient groups, service user groups and similar peer groups to share best practice, activities and learning to improve the way in which engaged and active patients are connected across our area. |
| New | Understanding our excluded population better | A project to consider working with local people who are considered to be socially excluded or sugaring health inequalities, discovering why they think this is and how we can rectify the situation |
| New | Maximising practice waiting rooms | A project to consider how waiting rooms are used at our practices. Helping coordinate and support practices to have a relaxing but engaging place for patients to wait for their appointment |
| New | Awareness training for voluntary organisations | A project to support awareness training for voluntary organisations |

## Enablers

| Information Technology | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0063 | Single system | A project to consider, vote on and, if appropriate, implement the move to all Practices using a single system as patients' health records currently sit in multiple clinical systems across a range of providers. |
| CL0071 | Electronic discharge | A project for a single secure e-discharge method for providers to send discharge summaries and out patient letters to practice |
| CL0072 | Sharing of homeless data | A project that shares health data across homeless practices to enable monitoring of individuals' use of clinical services. |
| CL0073 | The local eHealth record project (MIG) | A project to support our move towards a single-system and interoperability within Westminster |
| New | A single IT system | A project to support our move towards a single-system and interoperability within Westminster |
| New | Telehealth | A project to consider implementing telehealth solutions in one village to link to SystmOne upgrade. |

## Mental Health

| Mental Health | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| CL0015 | Mental Health contract with CNWL | A project to deliver efficiencies from Mental Health contract with CNWL by improving patient care out of hospital |
| CL0017 | Primary Care Plus (Mental Health) Service | A project that will deliver improved mental health outcomes in community and primary care services |
| CL0054 | Medically Unexplained Symptoms (MUS) | A project to improve patient choice for psychological therapies |
| CL0074 | Borderline Personality Disorder | BPD services are available within CNWL and the Tavistock and Portman. It is felt that these services can be delivered effectively in primary care, thus contributing to the shiftings settings of care work, whilst increasing options available to patients. |
| CL0075 | Family Therapy | Complex Families use a disproportionately high level of public sector services. In Westminster there is no funded family therapy available and this project will investigate the options for supporting families. |
| CL0076 | Psychoeducation | A project that is considering the education offered to people with a mental health condition |
| CL0078 | IAPT Gap (Psychological Therapies in Primary Care) | A project to give additional choice for patients seeking psychological therapies, increase in therapy available to patients to meet forecast prevalence & increase in appropriate therapies within primary care. |
| CL0079 | Dementia Trajectories | A project to improve the numbers of patients identified and supported with a dementia diagnosis |
| New | Step 4 therapies into primary care - Eating disorder service | A project to considered developing a primary care eating disorder service linked to student practices for early intervention where admission is not needed. |
| New | Actions to support the risk of suicide of men | A project to consider taking actioning to support men at the risk of suicide, as currently suicide is the highest killer of young men within the CCG |
| New | Identification of services for primary care | A project to consider working with GPs and consultants to review all Community and Acute MH services and identify those that can be managed within primary care. |
| New | Improved consistency in CAMHS services and identification of common mental health disorders in Children | A project to consider improving consistency in CAMHS services and identify common mental health disorders in Children |
| New | Dementia - current project is to increase number of early diagnosis patients. | A project to increase the number of early diagnosis patients |
| New | Review rapid access services | A project to consider improving the quality of the out of Hours services |
| New | Access to senior clinicians | A project to consider the provision of direct access services for GPs to senior psychiatric clinicians to increase effectiveness of communications streams and prevent unnecessary referrals to A&E. |
| New | User involvement in MH services | A project to consider reviewing current user forums and develop a plan for future patient and service user involvement. |
| New | Culturally appropriate talking therapies in primary care | A project to consider the language of talking therapies as Westminster has a diverse community |
| New | Post natal depression review | A project to consider reviewing current provision for patients with PND, identify gaps and implement solutions. |
| New | Step 4 therapy into primary care - schizophrenia | A project to consider working with mental health professionals to develop a specification for managing step 4 patients in primary care, identify numbers, seek funding and shift the setting of care for appropriate patients. |

## Joint Commissioning

| Joint Commissioning - Care Homes | | |
|---|---|---|
| Existing/New project | Project Name | Description |
| New | Review of provision to determine if we have the right number of care homes / nursing homes etc | A project to consider reviewing the provision to determine if we have the right number of care homes / nursing homes etc |
| **Joint commissioning intentions – Community Services** | | |
| New | Joint commissioning intentions – Community Services | Joint commissioning intentions – Community Services |
| **Joint commissioning intentions - Mental Health** | | |
| New | Joint commissioning intentions - Mental Health | Joint commissioning intentions - Mental Health |
| **Strategic contracting principles** | | |
| New | Strategic principles | Strategic principles |

**Appendix 3: An overview of NHS Central London CCG**

This document outlines the commissioning intentions for NHS Central London (Westminster) CCG for 2014/15 and builds on the commissioning plans implemented in 2013/14. They reflect the 2014/15 implementation of the CCG'S longer term strategic vision, commitment to commissioning for quality and the medium term financial strategy, and set out the areas where the CCG wishes to contract differently, improve quality or transform service delivery. For further information relating to the CCG'S strategy, please see the following documents:

- CCG Out of Hospital Strategy
- Shaping a Healthier Future
- Health and Wellbeing Strategy
- National planning guidance

This document describes the CCG'S high-level Commissioning Intentions for 2014/15 with a particular focus on those planned initiatives which will have a significant impact on contractual agreements with local Providers. Commissioning Intentions indicate to our current and potential new providers how, as a commissioning body, we intend to shape the healthcare system that the population in Westminster use. The purpose of these draft commissioning intentions is to inform providers and stakeholders of the changes in services or pathways that the CCG intend to commission for 2013/14. We will submit our Commissioning Intentions to the Health and Wellbeing Board for its endorsement and sign up to our plans for the year ahead and to the Commissioning Support Unit to inform the commissioning negotiation and planning cycle.

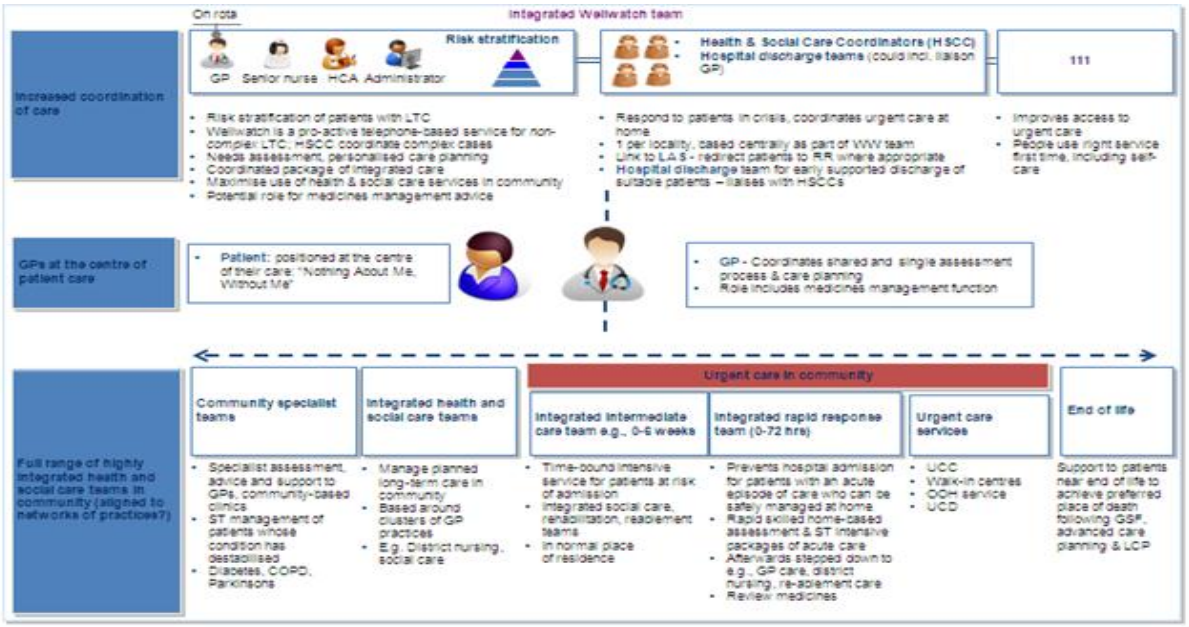
They also describe the work that the CCG will undertake during 2013/14 and 2014/15 prior to negotiating changes to services in subsequent years. In addition, the Commissioning Intentions includes services within existing contracts which the CCG are giving notice on or intend to give notice on in advance of undertaking a procurement for that service or of disinvesting in that service.
They will be further developed when the NHS planning guidance is published later in 2013.

This set of draft commissioning intentions represents the CCG'S plans during its second year of full operation and reflects the next steps in the implementation of our Out of Hospital Strategy that was published in May 2012. The strategy covers the period 2012-15 and describes our plans to transform delivery of community-based services in order to align with Shaping a Healthier Future, which is the NWL strategy for reconfiguration of hospital services.

The main themes of our commissioning intentions can be summarised as follows:

- Improve quality
- Ensure innovation
- Improve productivity
- Support prevention

They are visually presented in the diagram below placing the patient at the centre of patient care with the GP co-ordinating services and highlighting our intention to move towards greater co-ordination of care with integrated health and social care teams in the community aligned to our three GP localities.




We look after more than 180,000 people in Westminster and have high expectations for the way patients are cared for and the services they receive. NHS staff are totally committed to delivering high-quality care, but need to have the right workforce, skills and surroundings to guarantee this for all patients all of the time.

Increasingly, a number of different factors in Westminster are making it very difficult for us to provide high quality services consistently. The population is growing, and Westminster also has the second highest life expectancy in the country. This means the demand for our services is rising. The prevalence of chronic diseases, such as cancer, is higher than it has been historically and is leading to increases in emergency admissions because our out of hospital services are not operating as effectively as they should be. Patients tell us that they do not always have a positive experience of care.

In response to this, our vision is to:

- Bring care nearer to you so that as much as possible can be delivered close to your home. As part of our plans, within three years we will be spending between £5 million and £6 million more per year on our out-of-hospital services. By driving continuous quality improvement and innovation we will ensure we get the best value for money from this investment.
- Centralise emergency hospital care onto five specialist sites across NW London so that more expertise is available more of the time
- Incorporate all of this into one co-ordinated system of care so that all the organisations and facilities involved in caring for you can deliver high-quality care and an excellent experience, as much of the time as possible.

To achieve this we have proposed to:

- Deliver more services outside of hospitals, closer to people's homes
- Change some services at the following hospitals – Central Middlesex, Charing Cross, Chelsea and Westminster, Ealing, Hammersmith, Hillingdon, Northwick Park, St Mary's and West Middlesex.
- While most healthcare activity would remain where it is now, and all nine North West London hospitals will have local hospital services including an urgent care centre and outpatients, the changes proposed would impact on some A&E, maternity and paediatric and hyper-acute services at some hospitals in North West London.

*NHS Central London's Out of Hospital Strategy*

There is a clear case for the transformation of our out of hospital care. The health needs of our residents are changing as the population ages and people live longer with more chronic and lifestyle-related diseases. These trends are placing unsustainable pressures on our health and social care services and, under our current model of care, we will not have the resources available in the future to meet these demands.

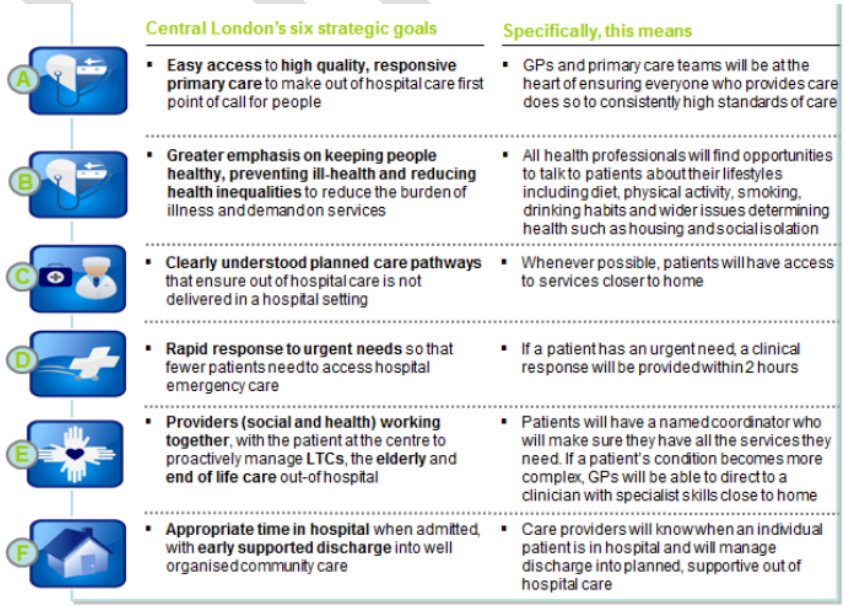
Currently, our health system is overly dependent on hospital services and patients end up in hospital when they don't need to be there. By intervening earlier, coordinating care and improving services in the community we can improve patient outcomes and value for money. Better prevention and care, closer to home, are the best ways to maintain people's health and quality of care in the face of increasing demand and limited resources.

At present, access to and quality of care are variable. There are differences in performance between GP practices and we know that our patients and health professionals are frustrated with the current system. Improving the access, quality and scope of out of hospital services will require new and innovative ways of coordinating services, more investment and greater accountability.

We want to make this promise to our patients registered with a GP within NHS Central London CCG:

> "We are committed to delivering care at the right time across integrated care pathways, which are coordinated across the health, social, community and voluntary sectors. We will put our patients at the centre, and develop a system that delivers recovery-focused patient outcomes".

What this means is that people will receive timely care that is organised to meet their needs. The services they require will be coordinated across sectors as a coherent package, with a focus on helping them to keep healthy, get better, prevent relapse and get on with their normal lives.
This promise translates into six goals as outlined in figure 3, which determine how we will change care in Central London.



*National priorities*

The CCG is fully committed to the principles of the NHS and sees its core function to commission high quality health services, delivered in the most cost effective way for its patients. We are committed to supporting the NHS Constitution, ensuring choice and enabling shared decision making. We also support the delivery of the NHS Mandate and will work in partnership with the NHS England deliver our mutual objectives.

*JSNA*

The area covered by CL CCG is a place of contrast with affluence and poverty side by side. Westminster generally performs well on health indicators. However in the areas with the highest social and economic deprivation the City performs less well. This means that there are significant differences in life expectancy and mortality between and within electoral wards in Westminster. The gap in life expectancy between the most and least deprived 10% of the population is 16.9 years for males, the largest gap in England, and 9.7 for females the largest gap in London (Marmot 2012). In addition, the most deprived fifth of the population live with disability for 21 years compared with those in the least deprived fifth who live with disability for 11 years. This too is the largest gap in England and has an impact on residents' economic dependence.

The health and wellbeing of Westminster's population is closely defined by the characteristics which makes Westminster a unique city.

*Health & Wellbeing Strategy*

Westminster City Council, general Practitioners, local health services and the voluntary and community sector already support those who reside, work, study and relax in the borough to live healthier lives. this includes providing high quality services and improving "wider determinants" of health, such as ensuring access to employment, open space, cultural and leisure facilities, good quality housing, an attractive, accessible and safe public realm and encouraging active travel.
The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 to improve the health and wellbeing of people living in, working in and visiting Westminster.

The Health and Wellbeing Board's vision for the future is that "all people in Westminster are able to enjoy a healthier city and healthier life". To help us achieve this, there are five clear goals that we are working towards over the next 15 years, until 2028:

- Improving the environment in which children and young people live, learn, work and play
- More people live healthily for longer and fewer die prematurely
- A safe, supportive and sustainable Westminster where all are empowered to play as full a role as possible
- People are supported to access appropriate quality care, closer to home
- People who are living with injury, disabilities, long-term conditions and their carers have quality of life, staying independent for longer

To help us achieve those goals, the Health and Wellbeing Board has identified five priorities on which to focus in the period 2013 to 2016.

- Every child has the best start in life
- Enabling young people to have a healthy adulthood
- Supporting economic and social wellbeing and opportunity

- Ensuring access to appropriate care at the right time
- Supporting people to remain independent for longer

**Appendix 4: Process to develop commissioning intentions**

*Introduction*

Each year, commissioning organisations within the NHS in England develop and publish a number of key planning documents, including a commissioning strategy, their commissioning intentions - how they plan to contract with providers to spend their resources effectively and efficiently - for the forthcoming year to deliver that strategy and finally an operating plan which details the specific plans the organisation will work to. The purpose of developing and producing these documents is primarily to ensure alignment between the strategic objectives for commissioners and providers of health care and health services and the consequent allocation of financial resource. Specifically, Commissioning Intentions should describe the services within existing contracts which the CCG are giving notice on or intend to give notice on in advance of undertaking a procurement for that service or of disinvesting in that service.

*Context in NHS Central London*

For NHS Central London CCG, 2013/14 represented the first year of our three year strategy. The documents represented the CCG'S plans during its first year of full operation and the next steps in the implementation of our Out of Hospital Strategy that was published in May 2012 and which covers the period 2012-15 and describes our plans to transform delivery of community-based services in order to align with Shaping a Healthier Future, which is the collaborative strategy for reconfiguration of hospital services.

We worked with stakeholders including patients, the public, our members and GPs, other groups and the Westminster Health and Wellbeing Board in the development of our plans. These plans were developed in line with the national planning guidance, Everyone Counts.

While there are a lot of unknowns about the planning process, including the national planning guidance and financial allocations, this does not stop us from beginning the planning process and acknowledging that this will be an iterative process. We do, however, have a very clear signal from the Comprehensive Spending Review that the Government intends for increasing the financial transfer from the NHS to local authorities year-on-year and this will have a significant impact on our budget from 2015/16, though we will need to do some preparatory planning in 2014/15. Practically, we will need to increasingly focus our efforts on integrated care and continue our partnership working with Westminster City Council.

One element of national policy that has been published is the consultation on a refresh to the NHS Mandate which signals the approach that the Government wishes the service to take in 2014/15. Whilst this level of detail isn't required to explain the planning process for 2014/15, it is a helpful indication to the CCG of a likely direction of travel. The full list of consultation questions is in appendix 1 and is summarised as:

- the actions being taken forward by NHS England in response to the Francis Report to transform the care people receive
- working with NHS England to develop a vulnerable older people plan, which will improve support for older people and those with long term conditions, particularly through reform of primary care given its pivotal role within communities
- the need for the NHS to contribute to the recovery of the economy and make better use of resources in light of the challenging financial climate

*Proposed approach for 2014/15*

The approach we wish to take to planning in 2014/15 will be guided by a number of principles:

- Clinically led with engagement from GPs, member practices and oversight from the Governing Body
- Patient and public involvement through the User Panel and other stakeholder groups
- A rigorous methodology to the process with the approach being led by the Transformation Support Team and decisions about projects being taken using project management principles

We will take a phased approach to the planning process which broadly follows the following structure.

- Phase 1: Context and input. This phase will commission and collate the information required to inform the commissioning planning process, including the JSNA which will inform both the clinical and financial context. This will start immediately and conclude at the end of August.
- Phase 2: Consultation on strategic aims. This phase will involve a workshop with Governing Body members and consultation with other key stakeholders to establish, based on the information from phase 1, whether the CCG'S vision, strategic objectives etc. are right. This workshop will happen in early September and we hope that this will be facilitated by the Strategy and Transformation Team. Included at appendix 3 is a Governing Body briefing on the current (2013/14) strategic position which will be reviewed.
- Phase 3: Project planning for 14/15. This phase will review existing projects and work-streams in addition to generating additional projects for consideration to deliver in 14/15 against the strategic aims. We aim for this to be particularly innovative, inviting patients and the public to text in their ideas for example, and to provide a base of projects for the CCG to pick from. This phase will take place in parallel with phases 1 and 2. Phase 3 might be considered the 'engine room' for the CCG; it should be the time at which lots of ideas are generated from a wide variety of stakeholders. We expect, during this phase, to identify the financial implications for all schemes so that we can build our QIPP plans from a wide base in 2014/15.
- Phase 4: Agreeing projects for 14/15. This phase will agree the main projects for delivery in 14/15 based on the previous phase and will take place in Mid-October. At this stage, we would want to begin the completion of project mandates and workbooks for approval by the CCG.
- Phase 5: Writing commissioning plans. Based on the agreed projects, the CCG will draft its commissioning intentions for wider consultation from early November.

We expect the following stakeholders to be involved throughout the process:

- Public
- GP practices (CCG members)
- Providers (Community / acute / voluntary etc.)
- CSU
- Local Authority
- NHS England
- CCG team
- Governing Body
- Sub committees
- Focus / user groups

**Appendix 5 – Framework Toolkit for Locally Commissioned Out of Hospital Services**

## 1. Purpose

The purpose of this toolkit is to assist CCGs in their decision making process for the commissioning of new locally commissioned out of hospital services, and to serve as a reference point when considering the appropriate procurement options for these services in the light of changes to the law since the Health and Social Care Act 2012 came into force.

The toolkit is primarily aimed at those services which were previously provided under a LESs in primary care.

CCGs need to balance the requirements of complying with the law and reducing legal challenge with the need to make effective and integrated commissioning decisions that are right for their local population. The aim of the toolkit is provide a framework that enables CCGs to do this quickly, efficiently and consistently.

Please note this does not constitute legal advice and does not replace the need for specific legal advice tailored to your individual circumstances.

## 2. Background

The Health and Social Care Act 2012 ("the Act") has brought in a new commissioning environment in which competition, patient choice and integration of services play a more prominent role.

At the same time, commissioning organisations have been restructured, with the creation of CCGs and NHS England. Primary care contracts are now managed by NHS England and in the light of this new guidance has been issued on the transitional arrangements for LESs.

This document is referred to as "Primary Medical Care Functions Delegated to Clinical Commissioning Groups: Guidance" (NHS England, April 2013).

NHS England has exercised its powers to transfer to CCGs:

- Management, on a transitional basis, of those local enhanced services for primary medical care and primary ophthalmic services that were originally commissioned by PCTs and for which responsibility has transferred to NHS England;
- Commission Out of Hours primary care services for their area; and
- Arrange GP Information Technology Services in their area.

At the same time, new regulations have been made that set out how the NHS should make decisions on procuring healthcare services, and inform the process CCGs should take to procure those services so as to reduce the risks of legal challenge. The full title of these regulations is the *NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013*, which have come into force under the Health and Social Care Act 2012. The general scheme of the Regulations is set out below.

## 3. NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 ("the Regulations")

The overall objective of the Regulations is described in Reg 2. These are:

- Securing the needs of the people who use the services;
- Improving the quality of the services; and
- Improving efficiency in the provision of the services.

In procuring health services, some of the principles which NHS bodies should adhere to in making decisions are described in Reg 3:

- Acting in a transparent and proportionate way;
- Treating providers equally and in a non-discriminatory way;
- Providing best value for money;
- Providing the services in an integrated way;
- Enabling providers to compete to provide the services;
- Allowing patients a choice of provider of the services.

**TABLE A: GENERAL REQUIREMENTS FOR COMMISSIONERS**

| | Descriptor | Regulations | | | |
|---|---|---|---|---|---|
| Objectives | What commissioners should secure | Secure Needs of Health Users (Reg 2(a)) | Improve quality of services (Reg 2(b)) | Improve efficiency of services (Reg 2(c)) | |
| Principles | How commissioners should act | Transparency (Reg 3(2)) | Proportionality (Reg 3(2)) | Non-discrimination (Reg 3(2)) | |
| Factors | Considerations in decision making | Patient Choice (Reg 3(4)(c)) | Competition (Reg 3(4)(b)) | Integration Reg (3(4)(a)) | Value for Money (Reg 3(3)b) |

## 4. Transparency

Commissioners must ensure that they conduct all of their procurement activities openly and in a manner that enables their behaviour to be scrutinised.

Actions that commissioners could take to increase their transparency could include:

- Publishing information on their future procurement strategies and intentions;
- Taking steps to ensure that providers are aware of their intention to procure particular services;
- Publishing details of contracts awarded;
- Maintaining appropriate records of decisions that have been taken, with reasons.

## 5. Proportionality

The process put in place to procure a service must be proportionate to the value, complexity and clinical risk associated with the provision of the service in question.

There may be circumstances where the costs of running a competitive tender process would be greater than the benefits of doing so.

One possible solution where the cost of running a competitive tender process are disproportionate could be for the commissioner to announce an intention to award a contract on the Supply2health website so that other providers have a reasonable opportunity to express their interest in providing the services. In the event that the commissioner receives expressions of interest, it would need to consider what steps it should take to ensure that its engagement with providers is consistent with the requirement not to discriminate between providers.

## 6. Non-Discrimination

Commissioners are under a duty not to favour one provider, or one type of provider over another. Differential treatment between providers requires objective justification.

Potential behaviours which could be viewed as discriminatory include:

- Giving one provider a more extensive role in engaging with the commissioner on service design, which could then give that provider an unfair advantage ahead of its competitors;

- Not giving providers an adequate opportunity to express an interest in providing a service

- Designing the service specification in a way that excludes a provider or category of providers unnecessarily and without objective justification in terms of service needs, efficiency etc;

- If a competitive tender process has been followed, the award criteria must not disadvantage a particular provider if this cannot be objectively justified. The award criteria must be applied in the same way to all providers.

## 7. Value For Money

To comply with Regulation 3, commissioners must ensure that when they enter into new contracts they do so with the most capable provider or providers that provides best value for money. By common definition, this means:

**QUALITY & PRICE**

A provider will provides best value for money where it delivers the best overall quality and price (where prices are not set). *The best value will not necessarily be delivered by the provider that supplies services at the lowest price.*

Monitor have stated in their May 2013 guidance[1]that the factors they are likely to take into account when assessing whether commissioners have complied with Reg 3 are:

| | |
|---|---|
| 1. | Has the commissioner taken steps to identify existing and potential providers interested in and capable of providing the services being procured by the commissioner? |
| 2. | Has the commissioner objectively evaluated the relative ability of different potential providers to deliver the service specification and to improve quality and efficiency? |
| 3. | Has the commissioner required prospective bidders to undergo suitable due diligence, as appropriate? |
| 4. | Has the commissioner considered both the short-term and long-term-impact of their commissioning decisions (including the sustainability of services)? |
| 5. | Has the commissioner taken account of the effect of bundling services together? |

## 8. Integrated Care

*National Voices* have worked with service user groups to derive a common definition of the meaning of integrated care. Under this definition care is delivered in an integrated way when "*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".*

Many patients have complex health care needs and need to access a wide range of health-related and social care services. Where care is provided to a patient by a number of different teams from different disciplines, there is a risk that patient care will be fragmented or that there will be gaps or delays in care.

The aim of integrated care is to address these issues and resulting in better patient experience and may lead to improved clinical outcomes and more efficient health care.

[1] *Substantive guidance on the Procurement, Patient Choice and Competition Regulations, Monitor 20th May 2013*

Factors that might affect the ability of providers to provide integrated care might include:

- Physical distance;
- Differences in working practices;
- Differences in operating systems or IT.

Integrated care may be connected with quality and efficiency. Commissioners should therefore wish to require potential providers of services to demonstrate how the different professionals and teams that are responsible for different aspects of an individual's patient care will co-operate with one another and how the provider will co-operate with third party providers that are responsible for other aspects of an individual patient's care.

**9. Choice and Competition**

Competition may be based on two different forms:

a. Competition based on patient choice. This is where patients can choose between multiple providers of the same or similar services. Depending on the circumstances, patients may be able to choose between different NHS organisations as well as third sector or independent providers;
b. Competition for contracts to provide services. This is where providers compete for the right to provide a particular service, e.g. where the commissioner runs a competitive tender and selects a single provider for that service.

Under the NHS Constitution, health care service users have the right to choose their GP practice and to be registered by that practice unless there are reasonable grounds for refusal. Also under the NHS Constitution, patients have the right to choose the organisation that provides their treatment when they are referred for a first outpatient appointment for a service led by a consultant, subject to certain exceptions.

Commissioners need to demonstrate that they have considered the potential to allow patients a choice of provider by entering into contracts to provide a particular service with more than one provider. They should also demonstrate that they have considered the potential of competition to drive up quality or improve value for money, with reference to the particular service in question. Conversely, commissioners should consider the impact of awarding a contract to a single or limited number of providers and the availability of credible alternatives.

In assessing whether a commissioner has complied with its obligations, Monitor will look at the following factors:

| | |
|---|---|
| 1. | Has the commissioner appropriately specified the services to be provided to ensure that the relevant statutory rights have been protected? |
| 2. | Do contracts entered into with providers responsible for making referrals to elective services impose positive obligations on providers to offer patients the relevant choices prescribed by law? |

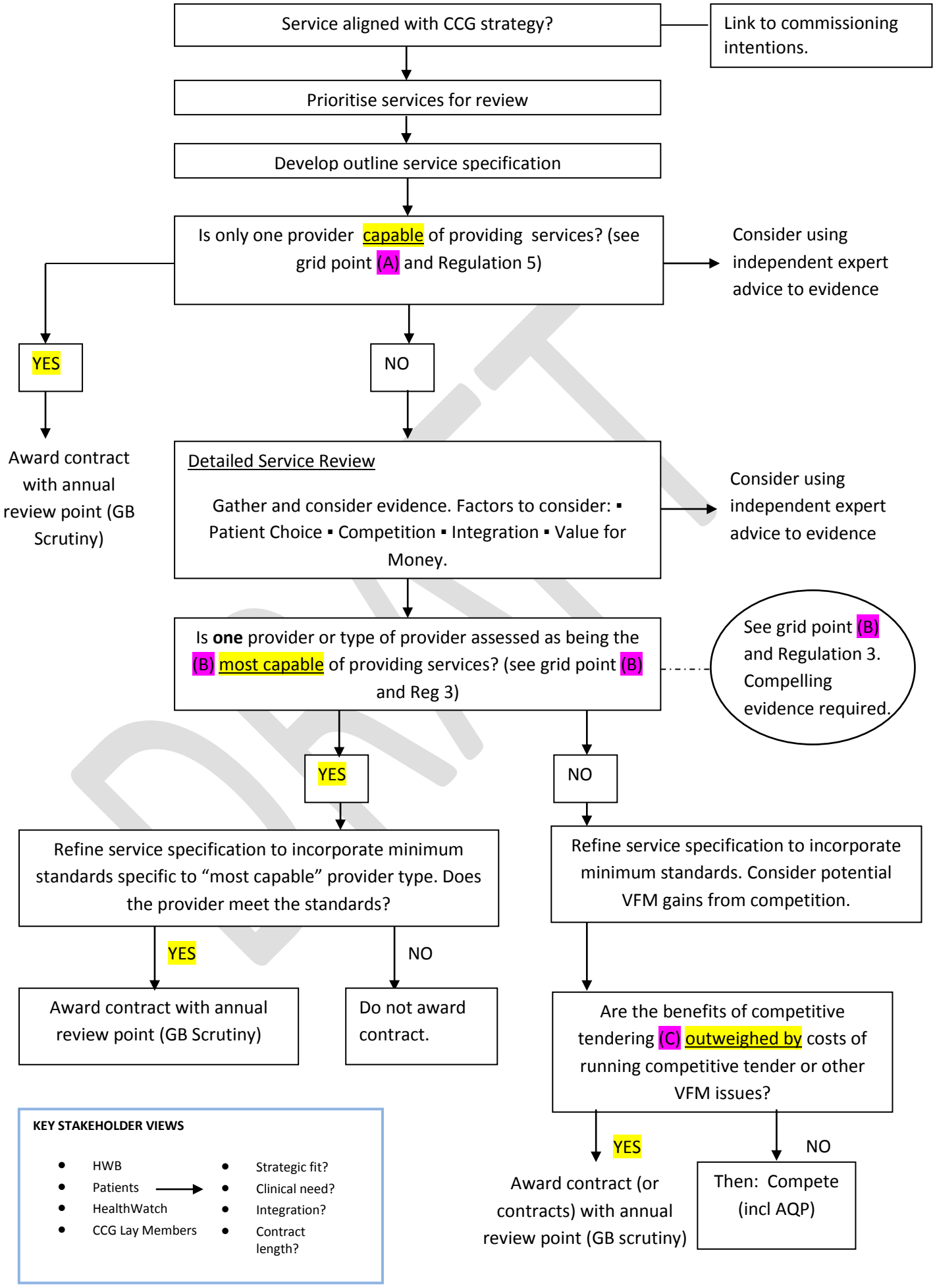
| | |
|---|---|
| 3. | What arrangements have commissioners put in place to ensure that health care users are aware of their rights of choice? |
| 4. | What steps have commissioners taken to respond to any evidence (whether as a result of complaints or otherwise) that patients for whom they are responsible are not being offered the choices that are protected by these regulations? |

## 10. Making Decisions About the Procurement Route

Having reviewed the service in question, commissioners will ultimately need to make a decision on the appropriate procurement route for an Out of Hospital contract. In some instances, there may only be a single provide capable of delivering the contract, and in these instances it is likely that the award of a single contract may be appropriate. In other circumstances, there may be several potential providers of the services in question, and commissioners will need to determine whether some form of competitive tender exercise is run, or whether a review process concluding in the award of a contract to a single provider would be more appropriate.

A decision tree is set out on the next page as an aid for commissioners:

# DECISION MAKING TREE FOR AWARDING OUT OF HOSPITAL CONTRACTS



**EVIDENCE GRID**

| | Consideration | Action | Evidence |
|---|---|---|---|
| **A** | **Is Only One Provider Capable Of Providing Services?** | | |
| | Guidance Note: Regulation 5 states that services are to be determined as capable of being provided by a single provider only when –<br>(a) For technical reasons, or for reasons connected with the protection of exclusive rights, the contract may be awarded only to that provider; or<br>(b) (only if it is strictly necessary) for reasons of extreme urgency brought about by events *unforeseeable by*, *and not attributable to*, the relevant body, it is not possible to award the contract to another provider within the time frame available to the relevant body for securing the provision of the services. | | |
| | | | |
| | **Consideration** | **Action** | **Evidence** |
| (i) | Necessary Infrastructure (real or capable of development) | Ensure there is only one provider with a clearly defined infrastructure necessary to deliver the service and a supporting rationale for this. Draft Board paper with supporting evidence. | Service specification (volume and capacity, sustainability, location, equipment, staffing)<br>Market analysis (from CSU or commissioned independently) of providers in the local market who could potentially provide the service, to include analysis of any risks to successful provision.<br>An independent clinical expert review would provide strong evidence. |
| (ii) | Clinical advantages of co-location with other services | Ensure there is a strong case that only one provider has the necessary co-location to provide the services, with a clearly defined rationale as to why it is necessary to have co-location. | Define Service Specification.<br>Utilise any evidence from Joint Strategic Needs Assessment or other Public Health reports that supports co-location.<br>Set out the evidence that the service is interdependent with other services (the basis of the co-location).<br>Even if co-location is required, consider whether this means the same provider has to provide the service, or whether several different providers could operate from the same site. |
| (iii) | Meeting immediate interim clinical need. | Demonstrate urgency of clinical need in report to CCG Board. | Set out circumstances leading to the immediate interim clinical need and demonstrating what the clinical need is.<br>Ensure appropriate performance metrics are |

| | Consideration | Action | Evidence |
|---|---|---|---|
| | | | built into contract to monitor quality.<br>Consider building in a shorter contract period if competition is still appropriate in longer term.<br>Ensure contract is monitored thoroughly once in place to satisfy CCG that patient needs are being met. |
| (iv) | Publish/transparency (15-30 days warning on web site) prior to award. | Publish intent to award contract on CCG website within 15 – 30 days | Publish on CCG website, to demonstrate steps being taken to identify all potential providers. |
| (v) | Capacity for improvement | Define performance metrics and levels of potential increase towards benchmarked standards. | Set benchmarks for issues such as speed of response, potential for integration, sharing of clinical data, sustainability, patient safety and activity.<br>This is particularly important in a 'monopoly' provider scenario where current service provision is below benchmarked standards.<br>Publish results, set these out to demonstrate clear benefits for the patient. |
| (vi) | Conflicts of interest | Board must manage conflicts of interest effectively | Ensure all actions/ decisions have a clear audit trail and comply with CCG governance processes and evidence minutes/ papers/ CCG policies. |
| **B** | **Is only one provider or providers assessed as being the most capable of providing services?** | | |
| | Guidance Note: Regulation 3 provides that the NHS must procure services from one or more providers that are:<br>• Most capable of delivering the objectives in the Regulations (i.e. secure health needs, improve quality of services, improve efficiency); and<br>• Provide the best value for money in doing so.<br>When acting with a view to improving quality and efficiency in the provision of services the relevant body must consider appropriate means of making such improvements, including through –<br>(a) The services being provided in an integrated way (including with other health care services, health-related services, or social care services); | | |

| | Consideration | Action | Evidence |
|---|---|---|---|
| | (b) Enabling providers to compete to provide the services, and<br>(c) Allowing patients a choice of provider of the services.<br><br>Monitor's May 2013 guidance states:<br><br>"In the context of the [detailed review], the commissioner may be able to identify with reasonable certainty those providers that are capable of providing the services…..In these circumstances it may appropriate to negotiate with those providers".<br><br>Note that even if one provider could be assessed as the most capable, there is still a need to consider whether competition and/or patient choice would offer additional benefits. | | |
| | | | |
| **B.** | **Consideration** | **Action** | **Evidence** |
| (i) | Service user needs and requirements. | Gather evidence around service user needs and incorporate into report to CCG Board, supporting case that provider or groups of providers are most capable. | Include in report evidence from:<br>- Joint Strategic Needs Assessment<br>- Public Health Information or reports<br>- Consider national and local service models which may best serve those needs, with clinical input as required<br>- Any recommendations of local clinical network<br>- Any relevant NICE guidance<br>- Evidence of standards of existing service provision (if any) from contract monitoring reports<br>- Compare existing standards of service provision with any benchmarked national standards (e.g. NHS Benchmarking Network reports) and gap between current provision and benchmarked standards<br>- Define appropriate service metrics for new service and scope for improvement.<br>- Develop service specification for the service.<br>- Demonstrate how the above supports the case that the provider or group of provider you have selected "most capable".<br>- Make report available on CCG website. |
| (ii) | Is the service the provider is offering compatible with other services? | Review service and establish key points of service compatibility. | - Collate and consider any national or local care pathways which include this service area, and the desired service specification.<br>- Consider any appropriate clinical |

| | Consideration | Action | Evidence |
|---|---|---|---|
| | | Consider using a recognised expert to identify interdependencies. | guidance covering the service area and its recommendations on which services should be interdependent on each other.<br>- Review any current service providers and how they are interdependent on other local service providers.<br>- Consider how the offering of the proposed service provider or providers would interact with any other services where an important interdependency has been identified. Compare this with any competing providers.<br>- Take into account supporting IT infrastructure and care pathways offered by proposed provider(s).<br>- If supported by the evidence, build a case that the proposed provider/s are most capable based on their compatibility with other interdependent services.<br>- Consider engaging a recognised expert to identify the clinical interdependencies and support choice of "most capable" provider or group of providers.<br>- Prepare report and seek agreement of CCG Board.<br>- Make report public on website. |
| (iii) | Engagement and consultation. | Consult with key groups on the award of the contract to a provider or groups of providers. | Consider consultation on the award of the contract with key stakeholders such as:<br>- Health and Wellbeing Board<br>- Local Healthwatch<br>- Local clinical networks<br>- Collected views and feedback to prove capability.<br>Sufficient information on the proposal should be provided to the groups to allow informed feedback. |
| (iv) | "Bundling" of clinical services (i.e. procurement of several different services from one provider as a "bundle") | Consider and justify if "bundling" (i.e several services from same provider) is clinically necessary and document in | Consider whether bundling is clinically necessary. This involves considering questions such as:<br>- Does the patient need to access the service from the same site as another service? |

| | Consideration | Action | Evidence |
|---|---|---|---|
| | | report. | - Does the patient need to receive the service in a particular setting?<br>- Would opting not to bundle services impact on the *sustainability* of a provider to deliver other, related services (for example if it makes it financially unviable)?<br>- Would achieving 'economies of scope' through bundling mean better value for money?<br>- Would bundling result in the exclusion of the most capable provider (i.e. most capable provider of one part of the bundle cannot provide another part of the bundle), thereby preventing the best provider being chosen?<br>- If a service needs to be provided to patients on a single site co-located with other services, is there a possibility it could be provided by *several* providers operating from the same site?<br>- Publish rationale on CCG website and regularly review contract during its lifetime to consider whether the rationale still stands.<br><br>An external, independent clinical view justifying "bundling" is likely to have the most weight. |
| (v) | Patient choice | Consider whether increasing patient choice is likely to have a positive impact on service quality.<br><br>Check action is consistent with CCGs' policies on choice and the NHS Constitution. | Demonstrate that the effect of patient choice on service quality is being considered and managed.<br>- Consider impact of single contract award on availability of alternatives for patients in the future;<br>- Document quality requirements for the contract and consequences of any breach and the duration of the contract.<br>- Document rationale for the procurement route (e.g. Board Executive papers);<br>- Require potential providers to demonstrate how different professionals and teams that are responsible for different aspects of an individual's patient care will co-operate |

| | Consideration | Action | Evidence |
|---|---|---|---|
| | | | with one another (where a provider provides more than one service) and how it will co-operate with third party providers;<br>- Where appropriate, incorporate contractual terms requiring multiple providers to share patient records and manage physical transfer of patients between sites. |
| (vi) | Network or group of providers as "most capable provider". | Consider whether a network or group of providers offer improved value for money or economies of scale, rather than contracting individually with single providers. | Evidence of proposed structure of legal entity of network or group.<br>Document any submissions made by proposed network and consideration of benefits that are likely to accrue from such an arrangement.<br>National or local evidence from other areas may exist to support the benefits of such arrangement - if so document this evidence and write supporting rationale.<br>Could a network have benefits in terms of sharing skills or continuity of care pathways?<br>Gather feedback from proposed network on benefits they might be able to offer. If alternatives to the network exist, consider announcing decision to buy from network on CCG website so that other categories of providers are aware of its intentions and able to express an interest in supplying services themselves. |
| (vii) | Conflicts of interest | Board must manage conflicts of interest effectively | Ensure all actions/ decisions have a clear audit trail and comply with CCG governance processes and evidence minutes/ papers/ CCG policies. |
| **C** | **Are the benefits of competitive tendering <u>outweighed by</u> the costs of running competitive tender or other VFM issues?** | | |
| | <u>Guidance Note:</u> The Monitor May 2013 guidance asks commissioners to consider whether the benefits of non-competitive behaviour outweigh the costs.<br>It states "Commissioners will need to determine on a case-by-case basis whether the costs of a | | |

| | Consideration | Action | Evidence |
|---|---|---|---|
| | competitive process would inevitably outweigh the benefits that could be achieved, or whether the process could be adapted so that it both secures the benefits of a contested process and is proportionate to the nature of the services being procured."<br><br>The guidance suggests a decision not to compete is more likely to be appropriate where the degree of clinical risk inherent in the service is low and/or the monetary value of the service is low. | | |
| C | **Consideration** | **Action** | **Evidence** |
| (i) | Proportionality test | Actions must be proportionate to the value, complexity and clinical risk associated with the provision of the service<br><br>Ensure you measure the amount of resources committed to procurement process compared to the value of services provided | Estimate of the costs of the procurement process.<br><br>Compare with likely contract value of services provided.<br><br>Commissioning intentions and priorities – do these match with the decisions for this service?<br><br>Include this information in Board Report justifying the procurement route. |
| (ii) | Assess value | Take into account all aspects of Value, including tender cost, patient flows (i.e. are there sufficient patients that would wish to access this service?), and costs incurred by provider in preparing bids. | Factor costs/benefits analysis into Board Report and consider publishing on CCG website. |
| (iii) | Assess clinical risk | Conduct risk evaluation using clinical expertise.<br><br>Ensure that impact of any relevant reconfiguration | Demonstrate that the clinical risk is low (higher risk services point towards a procurement because there is a need to closely examine competing offers on service quality) |

| | Consideration | Action | Evidence |
|---|---|---|---|
| | | exercises are taken into account | |
| (iv) | Case by case testing | Select random case examples to confirm low impact by value and clinical impact. | Publish sample size to demonstrate volume of testing |
| (v) | Conflicts of interest | Board must manage conflicts of interest effectively | Ensure all actions/ decisions have a clear audit trail and comply with CCG governance processes and evidence minutes/ papers/ CCG policies. |

The flow chart above has been drafted for the commissioning of health care services and is based on the CCGs' obligations under the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and Monitor's consultation guidance dated 20 May 2013.

## 11. CCG Standing Financial Instructions

Where a contract is to be awarded without seeking quotations or inviting bidders to tender, the tender waiver process set out in the Standing Financial Instructions must be complied with (see SFI 7(h) for specification as to the waiver requirements).

## 12. Contracts Relevant to the European Union

Where a contract could attract cross-border interest from countries within the European Union, different considerations would apply. Under this scenario the Public Contracts Regulations 2006 would affect the contract and the rules for Part B services would need to be followed. This would mean the contract would need to be advertised. Many Out of Hospital contracts will not attract cross-border interest but some of the larger value contracts (for example pathology services) could potentially attract interest from abroad.

## 13. Documenting Decisions

One important pointer to bear in mind is that decisions by CCGs to award contracts should be formally documented with reasons. A sound argument for selecting a particular procurement route and/ or provider can reduce the risk of challenge. Additionally, Reg 3(5) (b) requires CCGs to keep a record of how in awarding that contract it has complied with its duties as to effectiveness, efficiency etc and to improve the quality of services.

## 14. Publication of Contracts Awarded (Reg 9)

Regulation 9 requires commissioners to maintain and publish a record of all the contracts that they award on the website maintained by NHS England for this purpose. This is currently www.supply2health.nhs.uk.

Details to be included in the publication include:

- The name of the provider that the contract has been awarded to;
- A description of the services to be provided;
- The total amount to be paid under the contract;
- The dates between which the services will be provided;
- A description of the process adopted for selecting the provider.

## 15. Enforcement

Monitor has been given the power to investigate complaints that it an organisation has not complied with the Regulations. Monitor does *not* assess compliance with general procurement law (i.e. Public Contracts Regulations 2006) but, of course, commissioners must still ensure that they comply with these rules if they are relevant to the contract.

Monitor's powers

Monitor can:

- Investigate a complaint of non-compliance by a third party;
- Request information from a be given information by NHS England or CCGs about the subject matter of an investigation;
- Set aside a particular term of a contract if it restricts competition, is not necessary and is "sufficiently serious";
- Set aside a contract if NHS England or a CCG has not complied with certain parts of the Regulations and the failure is "sufficiently serious";
- Direct NHS England and CCGs to do certain things, including ordering action to comply with the Regulations, directing commissioners to vary arrangements or contracts for service provision or directing a commissioner to pay for a bidder's loss or damage.

**Summary of Key Obligations in NHS (Procurement, Patient Choice and Competition) Regulations 2013**

| Do the Regulations Apply? | What to build into your commissioning strategy | When must you open up to competition? | What must you do as part of your tender? | What records should you be keeping? |
|---|---|---|---|---|
| The Regulations apply to NHS England, CCGs and any other organisation providing procurement support. The Regulations also apply to CSUs. | How decisions are reached regarding the potential market for a particular service.<br><br>How a procurement will improve quality and efficiency in the service.<br><br>Consider if there could be any conflicts of interest or potential conflicts and if so ensure there is a robust process for dealing with them. | You should open up to competition unless:<br><br>• Only one provider capable of providing the services; or<br><br>• A detailed review has been carried out and a provider can be selected as the most capable, with reasoned justification and reference to the objective and principles in the Regulations; or<br><br>• The costs of a procurement would outweigh the benefits to be obtained from competition ( please see decision tree). | Advertise on *Supply2Health*. Include in the advert a description of the services and the evaluation criteria.<br><br>Ensure you have put in place arrangements for providers to express an interest in a contract.<br><br>Ensure your qualification criteria and any other criteria to establish a framework or AQP list is transparent, proportionate & non-discriminatory.<br><br>Ensure your contract does not include any anti-competitive provisions unless necessary to achieve beneficial outcomes or the first objective.<br><br>Publish on *Supply2Health* the following information about each contract:<br><br>• Name and address of provider<br><br>• Details & date of service provision<br><br>• Value of contract<br><br>• A description of the process followed | A full audit trail of any decision to procure a new contract, with reasons.<br><br>Reg 3 (5)(b) requires CCGs to maintain a record of how in awarding the contract it complies with its duties as to effectiveness, efficiency and improvement in quality of services.<br><br>Your process for ensuring you do not engage in anti-competitive behaviour unless it is in the interests of patients<br><br>How conflicts or potential conflicts were addressed in each process. |