NHS
West London
Clinical Commissioning Group

Commissioning Intentions 2014/15

NHS West London Clinical Commissioning Group

and The Royal Borough of Kensington and Chelsea and Westminster City Council

Our Vision

We are committed to developing personalised, integrated and joined up pathways of care across health and social care; shifting care from acute to community and primary care settings and reducing hospital admissions and improving early discharge.

NHS West London Clinical Commissioning Group
Covering The Royal Borough of Kensington & Chelsea and Queen's Park & Paddington in the City of Westminster

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Chair's foreword

I have been working locally as an NHS GP for over 15 years, and am pleased to be Chair of West London Clinical Commissioning Group, representing 54 general practices and approximately 230,000 patients in Kensington and Chelsea and the North of Westminster.

We have a culturally diverse population and significant local demographic variation, having some of the most deprived wards in London as well as some of the most affluent. People in the northern wards are twice as likely to die before 75 compared to those in the rest of the CCG. We have a high number of people of working age as well as an ageing population.

Our Commissioning Intentions for 2014/15 build on our existing out of hospital initiatives and outline our plans to further transform care for the future. We are committed to developing personalised, well co-ordinated and seamless pathways of care across health and social care; to shifting care to community and primary care settings; and to reducing hospital admissions and improving early discharge.

Working with colleagues in both the Royal Borough of Kensington and Chelsea and Westminster City Council, we wish to:

- Develop interventions that empower patients to stay healthy for longer, prevent ill-health and reduce health inequalities
- Develop a greater range of well-resourced services in primary and community settings, designed around the needs of individuals
- Ensure quality improvement and innovation across the whole system - this is central to our plans to deliver better value for money in the process
- Put the needs of patients first to ensure the co-ordinated and integrated delivery of health and social care.

The 2014/15 Commissioning Intentions set out ambitious yet realistic plans to transform out of hospital care and achieve better, more proactive care closer to home for the people of Kensington and Chelsea and North Westminster.

Dr. Fiona Butler, Chair of NHS West London Clinical Commissioning Group

1. Executive summary

This document outlines the Commissioning Intentions for West London CCG for 2014/15 and builds on the commissioning plans implemented in 2013/14. The Commissioning Intentions reflect the 2014/15 implementation of Shaping a Healthier Future, 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.

2014/15 will be the first full year for implementing our health care transformation programme in North West London, Shaping a Healthier Future, which sees the creation of 5 major acute hospitals and unprecedented investment in out of hospital services. The Commissioning Intentions across CWHHE[1] 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 to commission Whole Systems Integrated Care in shadow form for 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, the Royal Borough of Kensington and Chelsea and Westminster City Council and cover the services that we commission from these providers. These are set out in Section 3.

The Commissioning Intentions are written at two levels. At a strategic level they provide a consistent and coherent framework across the Tri-borough, 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.

[1] CWHHE is a Collaborative of 5 CCGs: Central London, West London, Hammersmith and Fulham, Hounslow and Ealing

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 from November 2013 and, collectively, we are known as CWHHE.

The decision to collaborate was reached because the CCGs felt that this configuration would:

- Enable each CCG to tackle cross-borough issues and give the maximum influence over decisions that span multiple CCGs, such as Trust Foundation Trust applications or the on-going 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.

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 and social care	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	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	
Carers		✓			✓	✓	✓					✓
Public Health		✓	✓	✓	✓	✓	✓	✓	✓			✓

2. CWHHE strategic contracting principles and intentions

There is a range of strategic principles and intentions that are consistent across CWHHE CCGs for all providers and which will form the basis of our contracting approach for 2014/15. These are:

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, encompassing patient safety, clinical effectiveness and patient experience
- Have in place and demonstrate robust systems and processes for safeguarding children and adults and ensure embedded learning from Winterbourne View and the Robert Francis Inquiry
- 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 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

- 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

- 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 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.

Strategic contracting intentions:

- 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 in order to support discharge planning

- 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 providers to have all clinics and services available on Choose and Book as directly bookable services 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:

West London CCG has chosen to work collaboratively with Central London CCG, Hammersmith and Fulham CCG, Hounslow CCG and Ealing 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, e.g. the development of a common Community Independence Service and a single team for the commissioning of nursing homes

- The implementation of a new service model for community nursing

- The development of a new service model for musculoskeletal services

- Shared contracting intentions for our major NHS acute, community and mental health providers

The way in which West London CCG will be implementing these goals is set out in sections 3 and 4.

3. CCG-specific Commissioning Intentions

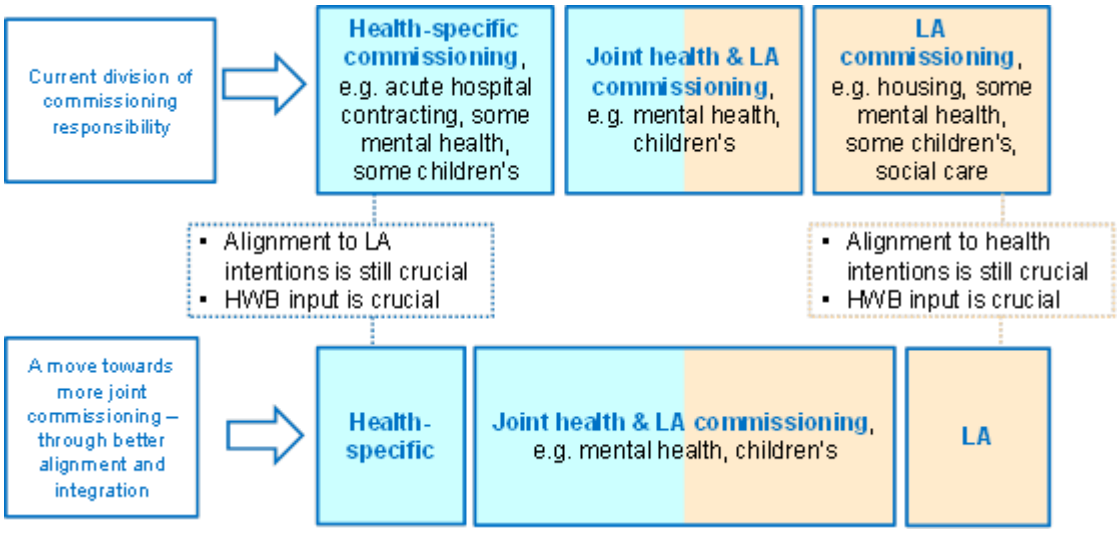
West London CCG has a wide-ranging work programme with associated Commissioning Intentions for 2014/15 which will ensure appropriate local progress towards achievement of relevant strategic objectives. This section details key priority areas and describes specific plans for the year in question.

West London CCG, the Royal Borough of Kensington and Chelsea and Westminster City Council work together closely as partners to commission care for our population. We recognise the importance of integrating services across health and social care to enable delivery of seamless care to our patients and clients. We are therefore pleased to be able to publish joint Commissioning Intentions in relevant areas as set out below.

We have organised our Commissioning Intentions according to the following categories:

- CCG-specific intentions
- Joint CCG and LA intentions
- LA intentions

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.



The CCG has undertaken engagement with a wide range of stakeholders to support the development of the Commissioning Intentions for 2014/15. Key themes that emerged from engagement activities included:

- Primary care access
- Communication with patients about how to access services, with particular focus on urgent care services and mental health services

- Education and support for patients, with particular focus on health and well-being and support for patients with long-term conditions
- Integrated care, with particular focus on sharing information across agencies and preventing social isolation
- Mental health

The full detail of feedback received is detailed in section 7, and the CCG's responses to the themes identified during the engagement process are outlined in the relevant sections of this document. The CCG has identified education for – and communication with – patients as an overarching theme which should underpin all work programmes during 2014/15 and beyond. In particular, our local community has told us that we need to target and tailor these communications to those who do not have English as a first language. The CCG will be developing its work plans for the coming years with this feedback in mind.

3.1 Integrated Care including Community Services – Joint Intentions

3.1.1 Whole Systems Integrated Care – Joint Intentions

Across CWHHE we have begun the process of designing a new model of care for our populations, which we think will bring benefits by creating an integrated approach between 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 ongoing evaluation and shared learning will run in parallel to these pilots. Based on these learnings, 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 2013.

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 the provider model
- How risk and savings will be distributed between providers
- Information requirements for outcomes and financial payments
- How the proposed provider group will work within existing system.

3.1.2 Putting Patients First – Joint Intentions

Our local model of integrated care is the Putting Patients First framework. Putting Patients First was established during 2012/13 and has risk stratification, care planning and case management at its heart. During 2013/14 the work of the Integrated Care Pilot (ICP) has been integrated with Putting Patients First, so Putting Patients First now includes elements such as multi-disciplinary case conferences, which are being developed into Network Learning Forums. As part of Putting Patients First, we expect that for vulnerable complex adults (and children), care will be provided as follows:

- There will be care plans in place for all patients with a risk score of 20+ and case management of all those with a need for care co-ordination[2]

- The care plan to have been co-designed with that patient and their carer where appropriate, and reviewed post discharge from hospital by the case manager and at regular intervals

- The care plan to describe the actions the patient will take to look after themselves and what support they can expect from a health and/or social care professional. The plan will also include practical arrangements for managing exacerbation of their condition

- Case management will involve the patient having a named case manager working with them. The case manager will have cross cover arrangements and the role will be carried out by community nurses, mental health professionals, allied health professionals, social workers or the GP, depending on needs of patients. High risk patients and those who are case managed will be discussed at monthly multi-disciplinary team meetings which will include case manager input. Care will be proactive and planned enabling a stable platform of care that can be stepped up and down appropriately to a community based response and acute hospital setting where necessary

- Care plans will have been discussed and agreed with multi-disciplinary teams where appropriate and all relevant providers will have been expected to provide appropriate input into these teams

- Where patients require specialist diagnostics and opinions this will be delivered around the patient and co-ordinated rather than the patient making multiple trips to hospitals

- The care plan will be shared across SystmOne with other providers (with patient consent)

- The care plan will include a full medication review and adoption of 'patient passport' or equivalent

- Care provided in people's homes will offer continuity by a team of staff aligned to the patient's GP – team can be made up of staff from multiple providers

- Patient transport where it is required to be co-ordinated between health and social care and provided in most accessible form for the patient

[2] Risk scores are calculated by an algorithm which takes into account factors which may put patients at risk of unplanned hospital admission. These factors include long-term conditions, history of non-elective admissions or attendances at A&E, age and a variety of other factors. The higher the risk score, the higher the patient's risk of hospital admission, meaning more input is required from health and/or social care services.

- If the patient is admitted to hospital then the GP should be informed within 24 hours in order to assist with the discharge planning. The CCG will work closely with providers to ensure that communication with GP practices (i.e. electronic discharge letters) is streamlined

- There is an expectation that number of patients with a risk score of 20+ covered by care plans will increase

- Patient experience of Putting Patients First will be evaluated, with GP practices being required to demonstrate that they are gathering patient experience of care planning and case management.

In 2014/15, we will actively promote supported self-care/self-management and empower communities to manage their own health. We will work closely with our local authority colleagues, including Public Health, to deliver this. This could mean:

- Targeted health education and co-ordination efforts between health and social care to maximise outcomes e.g. marketing flu campaigns
- Investing in third sector/preventative services that are targeted and evidence-based
- Designing new programmes around people
- Making more use of existing groups
- The potential role for community champions in working with patients and the public
- Working towards clear action plans that patients can follow which moves them to a self-care model
- Increasing the uptake of patient education programmes
- Increasing the use of electronic solutions and assistive technology, such as tele-health and tele-care, and exploring this with the local authorities
- The expansion of Personal Health Budgets.

The Primary Care Navigator project will be rolled out across the CCG as part of the Putting Patients First framework. The role will be developed to align with Putting Patients First and the CCG will ensure coverage of one Primary Care Navigator to every 20,000 people in the population to support older people with complex health needs.

As part of Putting Patients First, we will improve capacity and capability of community teams to support older adults in the community by commissioning an older adults' service, including an older adult specialist.

Patients and the public have told us that co-ordinated care following discharge from hospital is a high priority. The CCG will prioritise this in 2014/15, and explore the opportunities for increasing use of befriending and mentoring schemes to support those who may be isolated in our communities. In addition to this, patients and the

public have told us that interpreting services need to be strengthened to ensure that patients whose first language is not English are appropriately supported. The CCG will review interpreting services in 2014/15 and take appropriate steps as a result of the review to improve the quality of service being offered.

3.1.3 Community Services – Joint Intentions

Future Procurement of Community Nursing, Rehabilitation and Specialist Services

As part of our journey towards Whole Systems Integrated Care, CCGs and local authorities wish to see health and social care providers working together to deliver a co-ordinated holistic approach to all the needs of a person's health and well-being, both physical and mental. During 14/15 we will explore how different community providers can work in a co-ordinated way to deliver outcomes for patients and how payment mechanisms and other systemic elements can support this.

To support this ambition the CCGs, working with social care commissioners, will specify what we consider to be core community provision that will be commissioned and procured as a single entity. This in turn will allow us to move to outcomes-based commissioning. The specification of the core service will build on the work to develop a single specification for the Community Independence Service.

Where we commission multiple services from the same community provider during 14/15 we will expect these providers to implement ways of working which deliver integration and co-ordination between their services as well as the rest of the health and well-being system.

Over time other community services will be commissioned and procured as packages of services, reducing the number of service lines we commission and again allowing CCGs to move to outcome-based commissioning. We will appoint providers best able to deliver a package of services to meet patients' needs. The need to integrate and co-ordinate with other elements of the health and wellbeing systems will form part of all specifications.

Whilst there has been progress on the implementation of new models of delivery, particularly with regard to community nursing and rehabilitation during 13/14, much of this change has yet to be embedded in organisations and we will expect community providers to ensure these changes are owned by clinical staff on the ground and become 'business as usual'. It is through these models that we can deliver practical integrated care that benefits patients.

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. This approach is a fundamental component of the Pioneer Whole Systems Integration Plan. Progress has been made in 2013/14 to realign the existing district nursing services 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:

1. 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

2. The types of care being provided by the service by functional type and pathway, such as:

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

3. 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 co-ordinator 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.

Tri-borough Community Independence Service

Across the Tri-borough, in both 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 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

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

The Community Independence Service will be jointly commissioned by the three Clinical Commissioning Groups (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.

Other priorities

Community nursing services and specialist community services are essential to the delivery of Putting Patients First. The partnership between general practice, nursing leadership and social care professionals provides the most significant opportunity to transform the way that people are supported to achieve the best possible health outcomes and live independently and with resilience in the community.

In 2014/15 the CCG will:

- Commission community nursing services that are integrated with general practice to provide excellent care planning and case management through Putting Patients First

- Ensure that SystmOne facilitates the network of communication between general practice and a nursing leadership that responds rapidly to the needs of patients. This will include community nursing teams using SystmOne to record clinical activity

- Demonstrate a 5% productivity increase in community nursing resource

- Increase and realign stroke specialist neurological rehabilitation provision in secondary and community services to prevent over-stay in acute provision and prevent readmission within 6 months post-stroke

- Acknowledge the activity increases for community equipment and invest in additional funding to accommodate any projected increase. Increase in community equipment activity is expected as a result of increasing number of people supported to stay at home with community equipment and aids

- Continue to commission the Peripatetic (Outreach) Nurse Service for homeless people in the hostels with the most need in the WLCCG area. In addition, the CCG will continue to commission the Homeless Health Peer Advocacy Service to support homeless clients to attend their healthcare appointments and promote GP registration

- Identify opportunities for extending the use of tele-health and tele-care as a key enabler to achieve health and social care integration at the point of service delivery, focused on the needs of the individual. In 2013/14 West London CCG undertook a tele-health pilot for COPD patients in Queen's Park

and Paddington, and this was found to have potential to reduce avoidable non-elective admissions. The progression of this work is being considered under the CCG's work programme for respiratory services, and the CCG is also looking at other opportunities for extending the use of assisted living technology into other areas in 2014/15

- Work with other CCGs in CWHHE and beyond as appropriate to procure and implement a new wheelchair service.

3.1.4 Development of Community Hubs – CCG Intentions

As part of the Out of Hospital Strategy, West London CCG is developing community hub sites at St Charles and Earl's Court. These hubs will be established with the following principles:

- Serve as a base for the delivery of integrated community services, such as consultant-led community clinics, as a way of delivering care closer to home and away from hospital settings
- Serve as a base for regular contact among members of multi-disciplinary teams
- Allow local access to advanced diagnostic equipment
- Co-locate skilled health and social care staff in one place
- Act as a setting for engaging with and supporting patients and service users on the management of their own health and wellbeing.

Work is underway to develop business cases for the respective hubs which will inform the detail of specific services which will be delivered from these sites.

3.2 Integration Transformation Fund – Joint Intentions

The Integration 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 Clinical Commissioning Groups 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 thinks 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.

Areas 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
- 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 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. We will work with our providers on moving towards 7 day working for both acute and community services for urgent and emergency care, alongside the development of 7 day working in primary care services.

Specific areas of focus in 2014/15 will include:

- Urgent Care Centres (UCCs):
    - Implementing the Shaping a Healthier Future UCC specification in all of our UCCs, wherever they are commissioned.
    - Retendering of UCCs for St Mary's Hospital, Hammersmith Hospital and Charing Cross Hospital
    - Tariff renegotiation and review of pathways at Chelsea and Westminster Hospital
    - Review of St. Charles Urgent Care Centre contract

- 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 during 2014/15

- GP Out of Hours – re-procure in 14/15 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 hours provider). Integration with the 111 and UCC will be key

- Ambulatory Emergency Care – co-designing with primary care a service model with each acute provider on how these conditions will be treated

- IT – requiring the use of a system in all UCCs and in Medical Admission Units that is interoperable with SystmOne

- Full roll out of MCAP decision making software in identified Medical Admission Units

- Emergency admissions cap - retaining the emergency admissions cap on activity that is in place at Chelsea & Westminster and Imperial, and consideration of this at West Middlesex and Ealing

- Standards for consultant cover – 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

- Admission avoidance/rapid response teams – commissioning a 7 day a week service operating 08:00 – 23:00 with emergency night service for admission avoidance available to access from GPs/UCC/A&E. This will

include medical support from an older adults' service, including an older adult specialist

- Communication – developing direct communication links between LAS and GP practices to reduce unnecessary hospital attendance

- Information sharing – developing mechanisms to enable LAS, 111 and GP OOH services to view care plans

- Patient education – carrying out targeted patient education activities to raise awareness of ways of accessing urgent care. This will include supporting patients with self-care, through access to services such as pharmacies

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.

Critical care

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 and 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, we 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 Intensive Care Units to deliver primary care rehabilitation and case management for these patients.

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 to a fairer funding system during 2014/2015 and beyond.

Re-commissioning 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 during 2013/14 and are concluding which services they wish to commission via the new contracting mechanism in 2014/15. 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, re-commissioned in their current form using a standard NHS contract or re-commissioned 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 3

- 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 covering an identified patient population, with some practices treating patients from other practices in addition to their own patients for relevant conditions. We see this model as key to the delivery of Whole Systems Integrated Care and we will therefore identify 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. The 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 (Appendix 3) 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 the 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 tables below are subject to further assessment and testing by CCGs and the CCGs may amend these as further work is undertaken. The table on p.28-29 is an initial assessment of the groupings that services might fall into and where initial assessments indicate that general practice might be the most capable provider. The draft Out of Hospital Framework (Appendix 3) will be used to further test this.

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.

The following services will no longer be commissioned by the CCG and practices will be expected to sign up to the relevant DES:

Location	**LES**	**LES to DES**	**Note**
QPP	Learning Disabilities	Yes	from April 2014
QPP	Influenza	Yes	from April 2014

The following LESs have been decommissioned by the CCG during 2013/14:

Location	**LES**	**Decomissioned**	**Note**
QPP	IM&T	Yes	Decommissioned 1st October 2013
QPP	Choose and Book	Yes	Decommissioned 1st October 2013

Appendix 3 sets out the draft Out of Hospital Framework that we are using to make decisions regarding the future provision of services currently commissioned via LES.

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 Enhanced access to routine primary care Co-ordinate my Care Post operative wound care Ambulatory blood pressure monitoring Mental health – primary care plus services	In line with whole systems strategy that puts GPs at the centre of coordinating patients' care Requires clarity of accountability (which remains with GP Practice) or are list based services 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 Enhanced management of patients with long term conditions: • Anti-coagulation management for stable patients • Insulin initiation • Methotrexate prescribing • Services for homeless patients	Service will need to be integrated with existing care / provide continuity along a pathway Requires clarity of accountability (which remains with GP Practice) To provide best quality the service may need to make best use of scarce skills to serve a network of GP practices, though activity could be undertaken by individual practices Or Service could give patients choice of provider Service providers will need to utilise	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. To get coverage across networks sub-contracting across networks would be allowed

		SystmOne, the shared patient record	
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.** Phlebotomy Near patient testing (bloods only, excludes management and prescribing) Counselling Psychological therapy in primary care (IAPT)	Service will need to be integrated with existing care / provide continuity along a pathway 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 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. 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** Minor surgery Joint injections 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 competed during 2014 but in the short term contracts may be migrated over to NHS Contracts as a holding position

Other priorities for primary care

Patients and the public have told us that primary care should be one of our highest priorities. We have received feedback that GP appointment availability, flexibility of access and patients having enough time with their GP to discuss their needs, are all features of how primary care services need to be improved.

The CCG is developing a Primary Care Strategy which will reflect our vision for the delivery of high quality primary care services and will be working in partnership with the Primary Care Contracting team at NHS England. The CCG recognises the importance of primary care access and patient experience of primary care, and this will be at the heart of the Primary Care Strategy.

The CCG will look to foster a peer support framework which will facilitate shared good practice between GP providers and other primary care/community services based on closer working across the whole patient pathway.

The key priorities for 2014/15 will be:

- 7 day opening - commissioning a model of 7-day opening for primary care, ensuring availability of both bookable and walk-in consultations during evenings and weekends delivered on a locality basis at appropriate locations across the CCG to ensure full geographical coverage. This service will replace the existing extended and enhanced access services commissioned via the Local Enhanced Service (LES) mechanism. There will be a focus on ensuring access to primary care is flexible and convenient. In addition, the CCG will consider how to support patients who may need a longer appointment slot than is usually offered with their primary care clinician

- Prescribing – continuing to support GP practices to implement best practice prescribing guidelines in order to ensure the best possible quality of care for patients

- Mental health – commissioning a primary care-based mental health service to enhance the support to patients with mental health conditions in primary care

- Care planning and case management – embedding care planning and case management at the heart of general practice working to support vulnerable or complex patients

- Homelessness – commissioning a primary care-based homelessness service including outreach, which offers consistent service provision across the CCG

- Core GP standards – agreeing standards that all GPs to work to as part of NWL primary care transformation programme and remunerating appropriately

- Appointment booking – consideration of the feasibility of a single appointment system for primary care

- Choose and Book - increasing Choose and Book uptake as part of 14/15 Commissioning Learning Set Plan

- Networks – the development of GP provider networks for the provision of care outside of hospital across networks of general practices. Practices will work collaboratively to provide care across a wider population

3.5 Nursing, Residential Care and Domiciliary Care – Joint Intentions

We 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 client and familial involvement in placement selection, resulting in increased satisfaction levels

<u>Improving our commissioning</u>

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 homes 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 in number of block placements available and the number of providers who provide block placements.

Specific intentions for West London CCG and the local authorities in 2014/15 include:

- Commissioning up to 5 additional continuing care beds for clients with complex and high level dementia needs, to meet the increase in demand for specialist placements for clients with challenging behaviour and to prevent spot placements

- Putting in place robust medical cover arrangement for all care homes that are commissioned to provide services, including exploring options for rolling out the model developed and implemented by Ealing CCG

- Implementing Personal Health Budgets – in line with national requirements –

for people eligible for continuing health care in 2014-15 and preparing for wider implementation for people with long term conditions who do not meet the threshold for continuing health care from April 2015

- Increasing the numbers of clients who receive a continuing health care package at home to enable people to live independently in their own homes and die in their preferred place of care through the use of Personal Health Budgets, review of home care packages and an evaluation of night time care support

- Achieving equity and consistency in provision of continuing health care across the Tri-borough

- Reviewing the provision of night time care for end of life care across continuing healthcare, social care and specialist palliative care service to enable people to live independently in their own homes and die in their preferred place of care

- Ensuring arrangements for safeguarding adults for both health and the local authority are aligned and that joint approaches for the management of concerns, escalation and action are embedded in joint, coordinated multi-agency working.

3.6 Planned Care – CCG Intentions

NHS Improving Quality work programme

During 2013/14, CWHHE CCGs have been working closely with Imperial to review improvements and transform planned care in acute settings. This has been supported by the NHS Improving Quality 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, making 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
- Reducing patients having to “pin-ball” around the system – when multiple and sequential appointments are required for referred condition (including diagnostics/ sub-speciality transfers)
- Increased and consistent availability of one-stop and or joint speciality clinic availability across a range of specialities
- Increasing 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 are 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-to-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 outcomes to support the development of locality multi-disciplinary networks/ 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 the 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
- Consider or maximise the use of referral management 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 the 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 clinic, 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
- Consider mechanisms to enable patient moving straight to list from diagnostic for agreed conditions/diagnoses.

Within the contract discussions for 14/15 the following will be discussed and agreed:

- Incentivise providers to redirect to appropriate community services 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 out-patient 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)
- Quantify current IGR activity and targets for the 14/15 – 15/16 contracts
- Agree how CQUINS and KPIs can be used to enable the system and avoid any unintended consequences/disincentives
- Where appropriate agree local tariffs – for example for one stop shops and telephone consultations.

Other priorities for 2014/15

In addition to the above work, West London CCG will review the outcome of its current work with Chelsea and Westminster on post-GU clinic consultant-to-consultant referrals and will carry out an audit in-year of consultant to consultant referrals. The CCG will consider the benefits of a referral management system following the conclusion of this audit.

Furthermore, the CCG, in line with its Out of Hospital Strategy, has a clear ambition to ensure that care is provided close to patients' homes and within our local community. This approach facilitates patients to access care early in order to better manage the progression of long-term conditions and minimise the need for and reliance on high level – and therefore high cost – interventions in the future. The focus of this work-stream is to support patients in accessing care that is planned and co-ordinated rather than accessing care when in crisis, delivering early intervention and therefore prevention of acute exacerbations and non-elective admissions to hospital. The programme links two significant strategies for the CCG: Shaping a Healthier Future and Putting Patients First.

In line with Putting Patients First, the planned care work-stream addresses how care can be delivered by and with Provider/Community Health Networks, seeking to embed services within the community, co-ordinated by primary care and the extended multi-disciplinary team. Planned care commissioning intentions seek to ensure access to services across networks, with local access to specialist skills, advice and treatment.

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

In 2014/15 the CCG's priorities for planned care are:

- 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.

  Commissioning of the MSK service(s) in 2014/15 will seek to reduce the number of referrals to acute orthopaedic services. This will include making practical improvements to the existing services (central booking service,

GP direct access physiotherapy, CATs, pain management service) to achieve the reduction in referrals. These improvements would be consistent with best practice implemented locally. There will be development of commonly agreed referral criteria, with benchmarked data specific to each CCG, for diagnostics and referral agreed by the GPs, consultants and radiologists across CWHHE in the last part of 2013/2014 and all providers will be expected to work to these in 2014/2015.

During the quarter 4 of 2013/2014 work will be on-going to determine an appropriate service model for MSK services. It is likely that the CCGs will look to tender for this service during 2014/2015, though this will be subject to a local decision making process once the final service model is agreed.

- Diabetes – we will roll out a community diabetes service to ensure a single point of access for all GP referrals for diabetic care, providing tier 1-3 provision from St Charles Centre for Health and Wellbeing and other key sites in the CCG. The service will ensure early detection and proactive management of diabetes with specialist advice and intervention

- Cardiology and respiratory – we will further develop key community-based services for cardiology management and respiratory care and redesign care for patients with COPD. We will publish our procurement plan which is likely to include cardiology and respiratory services in the community. The CCG will also follow best practice guidance on management of 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 (ICHP), 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

- Diagnostic services – we will assess opportunities to redesign – and potentially procure – diagnostic services which ensure rapid access for patients and accessibility of results for professionals to ensure that patients get appropriate access to care in a timely fashion. Part of this work programme will include scoping options for direct access to diagnostics for GPs. This work programme links with our plans for developing a local primary care diagnostic formulary and ensuring the delivery of excellent near patient testing facilities

- Diagnostic cloud – we expect to see electronic sharing of all pathology results generated across NW London by end of 14/15 with plan to do so for radiology results

- Diagnostic formulary for primary care – we will agree with Imperial a diagnostic formulary for primary care

- Ophthalmology, gynaecology and urology – we will complete a review of the current models of care for ophthalmology, gynaecology and urology and agreement of an appropriate procurement plan where appropriate, linked to emerging networks

- Near patient-testing – we will commission a community-based near patient testing service for anti-coagulation monitoring, PSA monitoring and methotrexate monitoring

- Any Qualified Provider – we will use the Any Qualified Provider model where appropriate, including for termination of pregnancy services, which will be procured under Any Qualified Provider in 2014/15

- End of Life Care – we will build on Co-ordinate My Care implementation, implementation any recommendations from the review of the Liverpool Care Pathway, and develop a more holistic approach to end of life care

- Referral Standardisation – building on the Referral Standardisation Scheme implemented with general practices in 2013/14, we will continue to implement referral standardisation initiatives across primary care and to and between specialities and providers

- Long-term physical health conditions – we expect that patients with long-term physical health conditions will be screened for their mental health needs to ensure that care is delivered holistically

- Planned Procedures with a Threshold and Individual Funding Requests – West 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

3.7 Cancer – CCG Intentions

The CCG's priorities for cancer 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
- Urology patients requiring only monitoring of PSA levels to be discharged from hospital with follow-up in primary care.

Early detection 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 in 2014-15 and 45 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.

Endoscopy

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. Associated investment will be built into CCG's investment plan for 14/15 once relevant figures have been finalised.
- Ensure surveillance approach for symptomatic patients means all patients are recalled appropriately with no patient at risk of falling through the gap.

Recovery package

The objective is to build on the work in 2013/14, by increasing the percentage of people who are offered a Holistic Needs Assessment, Care Plan and Treatment Summary, as well as 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

Furthermore, the 2012/13 Macmillan patient survey has demonstrated patient experience of cancer treatment in London tends to be poorer than elsewhere in the country. To address this, the CCG will work with providers to ensure that pathways between specialist tertiary centres (such as the Royal Marsden), local hospitals (such as Chelsea and Westminster and Imperial), and GP practices and community services are joined up.

3.8 Mental Health – Joint Intentions

West 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 authorities 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 WLCCG 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 West 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 black and minority ethnic (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, West 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 Improving Access to Psychological Therapy (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.

- Community Service Transformation – as part of a CNWL-wide transformation programme, in partnership with all 5 CCGs, we will continue to redesign community mental health services, driving forward 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, caseload, performance against key metrics and workforce by CCG.

- Ensure that cross-border activity between CCGs is kept to a minimum to safeguard equitable access across CCG areas and promote effective, joined up treatment and care, between health and social care.

- Improving Access – base-lining and implementation of the operational standards, principles and procedures agreed across NWL (see Mental Health Access Policy for NWL, October 2013).

- 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 Strategic Clinical Network 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 will take place from 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 CLCCG) 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.

- 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.

- Whole Systems, Physical Healthcare and Parity of Esteem – as part of wider plans for community transformation we will be working to ensure a step change towards greater *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, improve self-management, and physical rehabilitation for people with functional or organic mental health needs to reduce length of stay and prevent avoidable readmissions to acute hospitals.

- The local authorities 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 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.

- 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 sign-posting to appropriate services

- Improve referral from primary care for dementia diagnosis by increasing assessment and diagnostic provision and care co-ordination

  - Undertaking a comprehensive review of older adult mental health services (KCW), alongside the review of Adult Mental Health, to ensure that the services are responsive to the needs of people with functional mental health needs. We will ensure users of older adult mental health services, and their carers, are involved in the review.

  - 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, 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.

- 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.

- Implementation of 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.

- 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.

- Measuring Outcomes, Testing Satisfaction, Assuring Quality, Delivering Value – development and delivery of a rationalised set of required monthly scorecard indicators, including national requirements, outcomes, productivity and performance metrics, to support NWL-wide benchmarking. To be in place

from April 2013 at the latest, for May reporting, and monthly thereafter in line with national contract timetable and requirements.

- Working with the local authorities 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.

- Implementing 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.

- Commencing 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 Child and Adolescent Mental Health Services to adults and from adults into older people's services.

- Working 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

- Working with Public Health to ensure that the health and well-being priority around substance misuse is addressed appropriately.

- Patients and the public have also told us that we should also focus on men's mental health and mental health advocacy. The CCG will consider opportunities for this during 2014/15.

3.9 Learning Disabilities – Joint Intentions

In 2014/15, West London CCG will continue to fund essential activity contained within the existing partnership agreements with our local authority partners. In addition the CCG will:

- 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 local authorities 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

- 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

- Continue to develop community provision to reduce avoidable Assessment and Treatment Unit (ATU) provision and to bring people back into the local area where this is more appropriate, in line with the Winterbourne View Concordat

- Undertake transitional work to identify children under 18 who are likely to use ATU services through adulthood and to re-direct them through more appropriate services, in line with the Winterbourne View Concordat

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's Services – Joint Intentions

Children's health and development needs are a central focus for West 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

We will improve the way in which we support children 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 network 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:

1. 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
2. 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
3. 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 (eg practice nurses), acute partners, specialists and other local partners (eg early years 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, West 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.

3.12 Services for Carers – Joint Intentions

The CCG and its local authority partners 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.

Planned areas of focus in services for carers for 2014/15 are outlined below:

- Carers Information and Advice service
- Carers and Young Carers Personal Budgets
- Carers Health and Wellbeing project
- Parent Carers Advocacy service
- Carers health screening project (relief care to attend health appointments or intervention that will impact positively on health outcomes)
- Extension of the Carer Primary Care Navigator role further to at least 6 more general practices in 2014/15
- Young Carers Fun and Fitness
- Young Carers Home-based Family Support Service.

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, the Public Health is in the process of re-commissioning the following services:

- Stop Smoking Quits and Prevention
- Reducing reoffending
- Reducing reoffending in women

- Substance Misuse Group Work
- Substance Misuse Primary Care Support
- Club Drugs Project

The re-commissioning of the above services impacts on the following providers: CLCH, CNWL, CRI, Blenheim, Westminster Drug Project, and Foundation 66.

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. More detailed provider impact analysis will follow.

Commissioning Intention	Gross Savings £k	Primary Care £k	Community (CLCH) £k	Mental Health (CNWL) £k	Acute (Imperial) £k	Acute (ChelWest) £k	Continuing Care £k	Other £k	Total £k	Investment £k	Primary Care	Community	Mental Health	Acute	Continuing Care	Net Savings (£000)
TRANSFORMATIONAL																
Emergency care																
Integrated care	4000				2400	1600			4000	1300	√	√	√	√		2700
UCC and A&E	500		200		150	150			500	200	√	√		√		300
Excess bed days	250				150	100			250					√		250
Sub total	4750		200		2700	1850			4750	1500						3250
Planned Care																
Outpatients	2300				1380	920			2300	700	√	√		√		1600
Paediatrics	100				75				100	25	√	√		√		75
Diagnostics	300				180	120			300	50				√		250
Sub total	2700				1635	1040			2700	775						1925
Medicines management																
Prescribing	1000	1000							1000		√					1000
TRANSACTIONAL																
Acute services	2100				1260	840			2100					√		2100
Community services	750		750						750			√				750
Mental Health Services	800			800					800				√			800
Continuing care	700						700		700						√	700
Consolidation of contracts	500							500	500							500
Sub total	4850		750	800	1260	840	700	500	4850							4850
TOTAL	**13300**	**1000**	**950**	**800**	**5595**	**3730**	**700**	**500**	**13300**	**2275**						**11025**

5. Procurement intentions

The purpose of this section is to highlight for providers those service areas where there is work underway and there is a significant possibility that we will undertake procurement exercises. 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. The table includes detail of new services where procurement will commence during 2013/14 to achieve service commencement during 2014/15.

Service area	**Indicative annual value £000s**	**Indicative procurement commencement date**
Existing services		
Community diagnostics	1,500	Q2 2014/15
Community respiratory	800	Q1 2014/15
GP out of hours	800	Q2 2014/15
Wheelchair services	TBC	TBC
Community dermatology	300	TBC
Community MSK	1500	TBC
NHS 111	650	Q2 2014/15
Re-commissioning of Enhanced Services**	TBC	TBC
New services		
Connecting Care for Children	TBC	Q3 2014/15
Community cardiology	650	Q4 2014/15

** See Primary Care section for details on re-commissioning Enhanced Services

6. Enablers

We are investing in the following areas to enable the delivery of our Commissioning Intentions:

Engagement with patients, carers and users

Patient and Public Engagement (PPE) is at the heart of the CCG and is embedded within the overall work of the CCG to drive improvements in health care.

The work to be undertaken in 14/15 builds on the framework and key achievements for PPE since April 2013. The CCG will continue to work with patient forums and key stakeholders to ensure the patient voice is at the centre of our decision making and priority setting. We will strive to empower communities to develop sustainable approaches to health improvement and promotion. In order to develop this we will build upon PPE training for CCG members, the patient reference group and wider CCG stakeholders, including the local population.

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
- Work together with CCGs within the CWHHE Collaborative and invest resources in the following areas:
    - 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
    - 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 stakeholders and staff. 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 to invest in the Patient Participation Group project. The CCG will continue its representation at key stakeholder meetings including Kensington and Chelsea Social Council Voluntary Sector Forum, the BME Health Forum and the North Westminster Network Forum. 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, through investment in targeted engagement projects.

People and organisational development

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

Our Commissioning Learning Sets (which are GP practice 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 Commissioning Learning Sets to support the delivery of QIPP, and the Commissioning Learning Sets ensure that our GP 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 the Network Learning Forums, which build on the multi-disciplinary groups established by the Integrated Care Pilot. They are underpinned by joint learning and working, with a multi-professional and multi-provider membership discussing cases in order 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 monthly 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 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. In addition, a local IT strategy is currently under development for the whole systems implementation within the framework of Shaping a Healthier Future 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 a 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:

- 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.

- 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.

- Working 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 take 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
- Summary Care Record

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 fundamental vision for the CCG is its commitment to the development of two community based hubs for the delivery of its Out of Hospital Strategy. There has been a particular focus on progression of the case for the future of the St Charles Centre for Health and Wellbeing in order to maximise the utilisation of this key community facility and benefit from potential integration of health, social care and third sector services operating from a single site. This must, however, be undertaken as part of a broader strategy for the overall estate, including the links with the southern hub in the Earls Court area and the requirements of the Primary Care Strategy.

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 is undertaking two key pieces of work relating to the service delivery within primary care facilities, and assessment of the overall functional suitability of primary care premises in the area, which has highlighted a need for significant investment over the coming years.

This work has been used to provide a capital investment pipeline which will be developed in conjunction with NHS Property Services Ltd and NHS England to plan

the investment profile to prioritise the programme and define the most effective delivery vehicle.

The CCG will continue to develop its Estates Strategy, which will be driven by the service models. It is anticipated that the cases for St Charles and Earls Court will be completed as part of this process 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.

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 Commissioning Learning Set (GP locality) infrastructure. Our 5 CLSs 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 CLSs 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.

To complement this is a new role for our Network Learning Forums (formerly multi-disciplinary groups), which will work alongside providers to influence change and shift settings of care in line with our key strategic priorities.

7. Stakeholder engagement

The Commissioning Intentions for 2014/15 have been developed based on feedback from various stakeholder groups, including patient and public groups, Health and Wellbeing Boards for both Westminster City Council and the Royal Borough of Kensington and Chelsea, and the CCG GP membership. A full list of meetings and forums attended is shown in Appendix 2.

The themes that have arisen from the engagement we have undertaken with patients and the public are as follows:

Feedback received	How this fits into 14/15 plans
Urgent care	
• Increase in GP appointments and improve access • Improve paediatric urgent care in general practice	• GP access is included in the Commissioning Intentions and will be included in the Primary Care Strategy • We are developing Child Health Hubs to strengthen skills and expertise in general practice. This is included in the Commissioning Intentions
Primary care	
• Build confidence and trust in GP practices • Longer GP appointments • Training for reception staff in GP practices	• We are developing a Primary Care Strategy which will cover these topics and look at how we build capacity and capability in general practice
Patient education and support	
• Patient education programmes • Targeted advice on healthy lifestyle and diet • Information on UCC, A & E and 111 and when and how to access • Directory of available services – including how migrant and refugee communities can access health care • Patient education on mental health and how to access services	• We are developing a plan for patient education and communication to address how we support patients with accessing services • We will work with Public Health colleagues to look at how we strengthen healthy lifestyle and diet services • Broadening access to mental health services is a key priority in the Commissioning Intentions, particularly for those in BME groups as part of the equality objectives

Integrated care	
• Co-ordinated discharge plans to include social interaction and practical help • Interpreting services • Sharing patient notes across agencies • Befriending services/social interaction • Integration of community and hospital services	• Integrating care, including co-ordinating care after discharge and sharing of notes, are a key part of the CCG's Commissioning Intentions • We will look at how we can increase the use of befriending and other support services as part of our planning for next year • We are considering how best to take forward the feedback on interpreting services and have included this in our Commissioning Intentions
Mental health and substance misuse	
• Support for alcohol related admissions • Support for mental health crisis • Mental health advocacy • Focus on men's mental health • IAPT locations and reduce mental health stigma • Increase support for low level mental health needs • Review how BME groups access mental health services	• Mental health is a major priority area in the Commissioning Intentions, and there is particular focus on improving urgent care assessment • We are focusing on delivering mental health services in the community where appropriate • We have an equality objective about improving access to mental health services, particularly for BME groups • We will look in more detail at how we can focus on men's mental health and mental health advocacy

The engagement we have undertaken will help shape how the CCG takes its plans forward in 2014/15. In particular, we have noted that patients and the public would like the CCG to focus on giving people the tools to stay healthy and to look after themselves, and this will be a priority area for the CCG going forward.

8. Conclusion

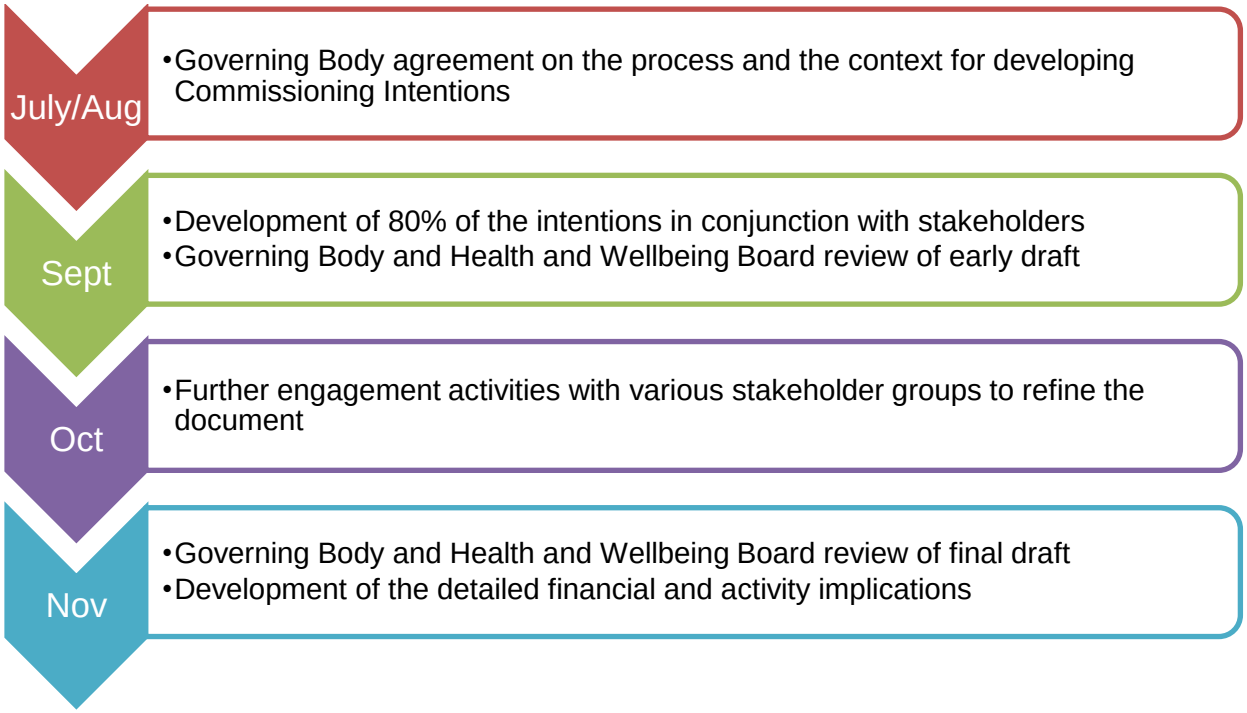
This document sets out the commissioning intentions for West London CCG. They are intended to drive major transformation across the services that we provide to ensure that patients receive higher quality, more integrated care with an enhanced patient experience. We expect providers to respond proactively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

Appendix 1 – Detailed provider impact analysis

Detailed analysis at provider level will follow.

Appendix 2 – Process to develop Commissioning Intentions

The process followed by West London CCG to develop the Commissioning Intentions for 2014/15 is outlined in the diagram below:



The Commissioning Intentions may also be subject to further review in December 2013, when NHS England publishes its national planning guidance for 2014/15.

The CCG also took targeted information and questions to other stakeholder groups, including GP practices and patients and the public, and the feedback from these events is highlighted in section 7 of this document. The events attended were as follows:

Event	Attendees
GP Commissioning Learning Sets (September and October)	GP practices
Patient Participation Groups	GP practice patients
Healthwatch event	Local residents in Tri-borough area
North Westminster Community Network	Third sector groups who work with the local population in Queens Park and Paddington (BME groups, residents of the local estates, families on low income, English as a second language)
BME Health Forum	Tri-borough groups who work with black and minority groups around health issues
Dalgarno Coffee Morning	Residents on Dalgarno estate in the north of

	the borough; English as a second language; low income; single parents; people with long-term conditions; BME groups
Golborne Health Fair	Young people 13 to 25; single young parents; young people with learning disabilities; BME young people
Patient Reference Group	Patient groups in the WLCCG area
Silver Sunday event	Older people 65+ in Earl's Court area
Older People's Health Fair	Older people across the Tri-borough
Diabetes User Group	Tri-borough people with diabetes
PPE Committee	Third sector reps; Healthwatch
K&C Social Council	Third sector organisations in K and C
Earl's Court Coffee Morning	Residents in Earls Court area with LTC (mental health; learning disabilities; older people; substance misuse)

The themes arising from these events are summarised in section 7.

Appendix 3 – 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[3] 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

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

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.

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.

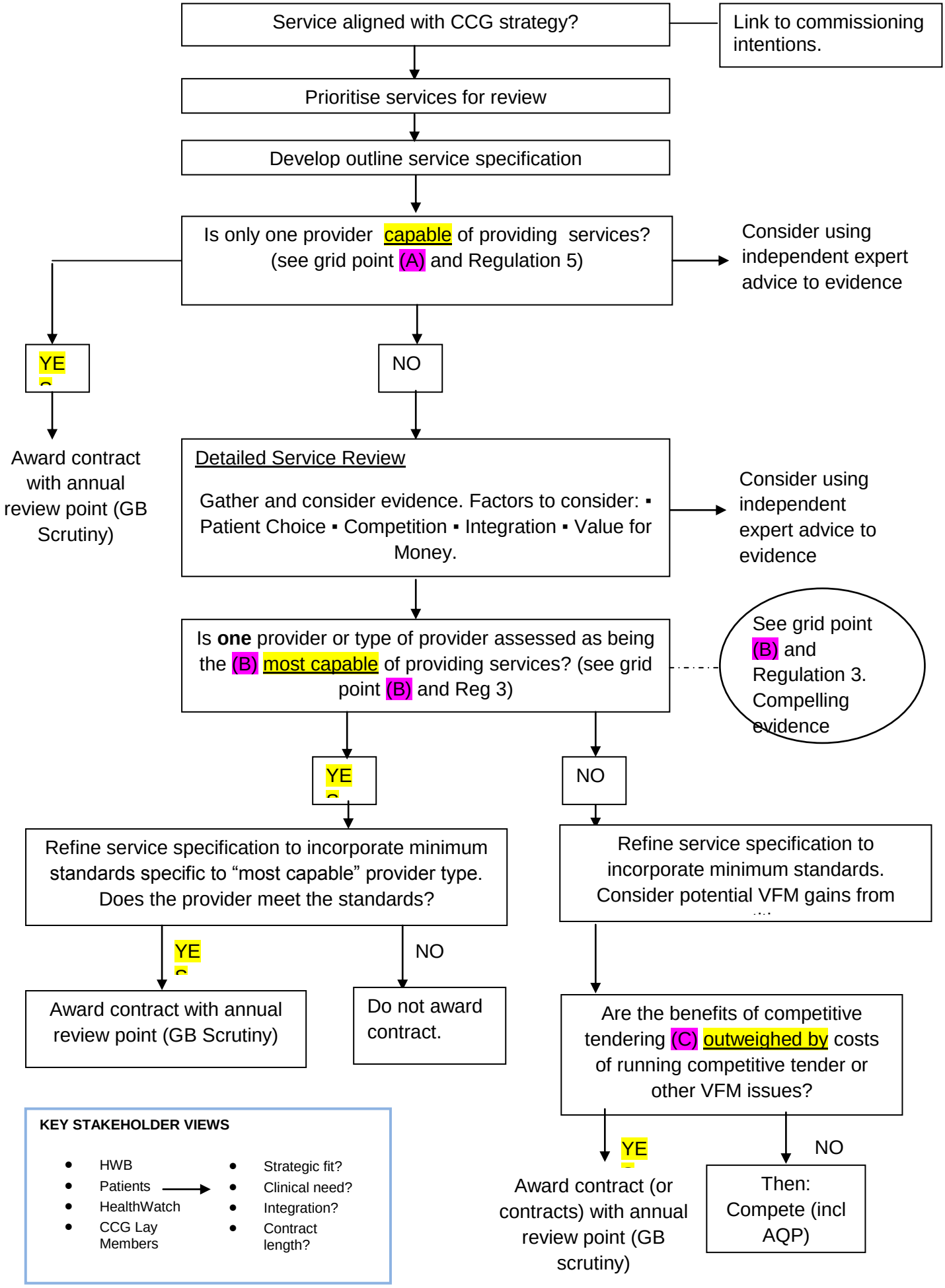
In assessing whether a commissioner has complied with its obligations, Monitor will look at the following factors:

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 – (a) For technical reasons, or for reasons connected with the protection of exclusive rights, the contract may be awarded only to that provider; or (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) 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. 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. Utilise any evidence from Joint Strategic Needs Assessment or other Public Health reports that supports co-location. Set out the evidence that the service is interdependent with other services (the basis of the co-location). 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

	Consideration	Action	Evidence
			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. Ensure appropriate performance metrics are built into contract to monitor quality. Consider building in a shorter contract period if competition is still appropriate in longer term. 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. This is particularly important in a 'monopoly' provider scenario where current service provision is below benchmarked standards. 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.

	Consideration	Action	Evidence
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: • Most capable of delivering the objectives in the Regulations (i.e. secure health needs, improve quality of services, improve efficiency); and • Provide the best value for money in doing so. 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 – (a) The services being provided in an integrated way (including with other health care services, health-related services, or social care services); (b) Enabling providers to compete to provide the services, and (c) Allowing patients a choice of provider of the services. Monitor's May 2013 guidance states: "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". 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: - Joint Strategic Needs Assessment - Public Health Information or reports - Consider national and local service models which may best serve those needs, with clinical input as required - Any recommendations of local clinical network - Any relevant NICE guidance - Evidence of standards of existing service provision (if any) from contract monitoring reports

	Consideration	Action	Evidence
			- 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 - Define appropriate service metrics for new service and scope for improvement. - Develop service specification for the service. - Demonstrate how the above supports the case that the provider or group of provider you have selected “most capable”. - 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. Consider using a recognised expert to identify interdependencies.	- Collate and consider any national or local care pathways which include this service area, and the desired service specification. - Consider any appropriate clinical guidance covering the service area and its recommendations on which services should be interdependent on each other. - Review any current service providers and how they are interdependent on other local service providers. - 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. - Take into account supporting IT infrastructure and care pathways offered by proposed provider(s). - If supported by the evidence, build a case that the proposed provider/s are most capable based on their compatibility with

	Consideration	Action	Evidence
			other interdependent services. - Consider engaging a recognised expert to identify the clinical interdependencies and support choice of “most capable” provider or group of providers. - Prepare report and seek agreement of CCG Board. - 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: - Health and Wellbeing Board - Local Healthwatch - Local clinical networks - Collected views and feedback to prove capability. 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 report.	Consider whether bundling is clinically necessary. This involves considering questions such as: - Does the patient need to access the service from the same site as another service? - Does the patient need to receive the service in a particular setting? - 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)? - Would achieving ‘economies of scope’ through bundling mean better value for money? - Would bundling result in the exclusion of the most capable provider (i.e. most capable provider of one part of the bundle

	Consideration	Action	Evidence
			cannot provide another part of the bundle), thereby preventing the best provider being chosen? - 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? - Publish rationale on CCG website and regularly review contract during its lifetime to consider whether the rationale still stands. 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. 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. - Consider impact of single contract award on availability of alternatives for patients in the future; - Document quality requirements for the contract and consequences of any breach and the duration of the contract. - Document rationale for the procurement route (e.g. Board Executive papers); - 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 with one another (where a provider provides more than one service) and how it will co-operate with third party providers; - Where appropriate, incorporate contractual terms requiring multiple providers to share patient records and manage

	Consideration	Action	Evidence
			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. Document any submissions made by proposed network and consideration of benefits that are likely to accrue from such an arrangement. 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. Could a network have benefits in terms of sharing skills or continuity of care pathways? 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. It states “Commissioners will need to determine on a case-by-case basis whether the costs of a competitive process would inevitably outweigh the benefits that could be achieved, or whether the process could be adapted so that it both		

	Consideration	Action	Evidence
	secures the benefits of a contested process and is proportionate to the nature of the services being procured." 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 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. Compare with likely contract value of services provided. Commissioning intentions and priorities – do these match with the decisions for this service? 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	Demonstrate that the clinical risk is low (higher risk services point

	Consideration	Action	Evidence
		clinical expertise. Ensure that impact of any relevant reconfiguration exercises are taken into account	towards a procurement because there is a need to closely examine competing offers on service quality)
(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?

The Regulations apply to NHS England, CCGs and any other organisation providing procurement support. The Regulations also apply to CSUs.

What to build into your commissioning strategy

How decisions are reached regarding the potential market for a particular service.

How a procurement will improve quality and efficiency in the service.

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.

When must you open up to competition?

You should open up to competition unless:

- Only one provider capable of providing the services; or
- 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
- The costs of a procurement would outweigh the benefits to be obtained from competition (please see decision tree).

What must you do as part of your tender?

Advertise on *Supply2Health*. Include in the advert a description of the services and the evaluation criteria.

Ensure you have put in place arrangements for providers to express an interest in a contract.

Ensure your qualification criteria and any other criteria to establish a framework or AQP list is transparent, proportionate & non-discriminatory.

Ensure your contract does not include any anti-competitive provisions unless necessary to achieve beneficial outcomes or the first objective.

Publish on *Supply2Health* the following information about each contract:

- Name and address of provider
- Details & date of service provision
- Value of contract
- A description of the process followed

What records should you be keeping?

A full audit trail of any decision to procure a new contract, with reasons.

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.

Your process for ensuring you do not engage in anti-competitive behaviour unless it is in the interests of patients

How conflicts or potential conflicts were addressed in each process.