NHS
West London
Clinical Commissioning Group

West London CCG Contracting Intentions 2015/16

Contents

1. Introduction

The purpose of this document is to set out for providers the priority contracting intentions for NHS West London Clinical Commissioning Group (CCG) for 2015/16, which will inform contract negotiations. This document should be read in the context of the CCG's wider commissioning plans and with reference to the strategic context set out in the next section.

2. Strategic context

The 8 CCGs in North West London, with our local authorities and other partners, are in the process of implementing widescale changes to the way in which patients experience and access health and social care. These plans are ambitious and transformational, and the vision is set out below.

We want to improve the quality of care for individuals, carers, and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

This vision is supported by 3 principles:

1. *People and their families will be empowered to direct their care and support and to receive the care they need in their homes or local community*
2. *GPs will be at the centre of organising and coordinating people's care*
3. *Our systems will enable and not hinder the provision of integrated care.*

We started the implementation of this vision in 2013/14, and have been putting many of the fundamental building blocks in place during 2014/15. Some of the key enablers have been:

- Putting Patients First, Primary Care Navigators and the Community Independence Service
- 7 day working in primary care and social care
- Development of GP federations, which has commenced in 2014/15
- Development of Out of Hospital contracts, which will be commissioned at network/locality level later in 2014/15, replacing practice level local enhanced services and ensuring wider population coverage
- Closure of Hammersmith Hospital Emergency Department and Central Middlesex A&E unit
- Implementation of a single GP IT system, SystmOne, across the majority of practices in West London, with all practices due to migrate by December 2014
- Establishment of Whole System Integrated Care early adopters, with business cases for implementation from April 2015 being developed
- Contracts with all key NHS providers that incentivise the transformation of services and the movement of services out of hospital

We intend to build on this further during 2015/16.

3. Approach to the contracting round

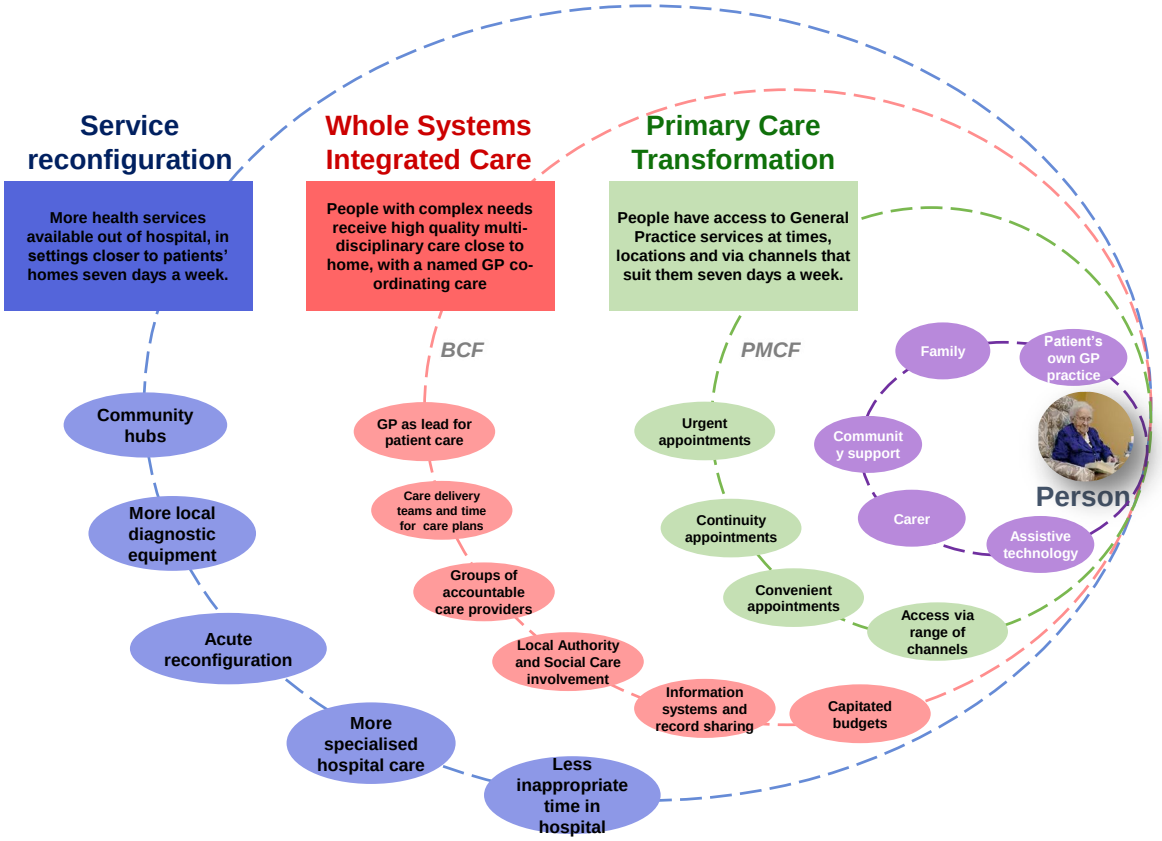
Our approach to the contracting round will build on the approach taken in 2014/15. We will be working closely with the other CCGs in CWHHE, and also with our colleagues in Brent, Harrow and Hillingdon, to maintain strategic alignment. Our primary objective is the delivery of our strategic vision, and we expect to negotiate contracts that will support us in the delivery of that vision, with a focus on transformational change and service integration. We will expect our providers to demonstrate how they are transforming their services to meet that challenge and how they are moving towards the SAHF service standards. We will seek to ensure that the incentives and penalties within contracts are aligned to ensure the delivery of the required transformation. All CCGs in NWL have whole systems integrated care early adopters who are developing models of care, and we expect to commission these during 2015/16, either in shadow or live form. We expect to reflect this within our 2015/16 contracts with the relevant providers.

Patient empowerment, and putting the patient at the heart of all we do, is fundamental to our vision. Generally providers are not doing this at present. We will seek to embed a requirement for much greater patient focus within our contracts for 2015/16.

We intend to start our contract negotiations earlier for 2015/16, with the aim of agreeing the baseline activity and many of the schedules before Christmas, subject to any changes that may be required as a result of the publication of planning guidance and 2015/16 tariffs in late December. This will give us the opportunity for better quality discussions and earlier certainty regarding 2015/16, enabling better planning and therefore a greater chance of delivery of the agreed changes. We expect all contracts to be signed by 31 March 2015.

4. Strategic priorities for 2015/16

Our vision is underpinned by the 4 key workstreams of i) Service reconfiguration under *Shaping a Healthier Future*; ii) Whole Systems Integrated Care; iii) Primary Care Transformation and iv) Patient Empowerment. This is shown in the diagram below.



We are currently developing the 5 year roadmap that sets out all the key milestones over the next 3-5 years to ensure that the vision is realised. The following section sets out the delivery priorities and milestones for 2015/16 against each of these key programmes.

4.1 Service Reconfiguration

Shaping a Healthier Future (SaHF), the acute reconfiguration programme in NW London, will centralise the majority of emergency and specialist services (including A&E, Maternity, Paediatrics, Emergency and Non-elective care) to deliver improved clinical outcomes and safer services for our patients. Agreed acute reconfiguration changes will result in a new hospital landscape for NW London. The SaHF Reconfiguration programme will oversee:

- The existing hospital landscape of nine hospitals reconfigured to provide five Major Acute Hospitals;
- Ealing and Charing Cross sites redeveloped, in partnership with patients and stakeholders, into Local Hospitals;
- Hammersmith Hospital established as a specialist hospital; and
- Central Middlesex Hospital will be redeveloped as a Local and Elective Hospital.

<u>Clinical Standards</u>

The programme supports the achievement of enhanced clinical standards. As part of the original development of NW London's vision, NW London's clinicians developed a set of clinical standards for Maternity, Paediatrics, and Urgent and Emergency Care, in order to drive improvements in clinical quality and reduce variation across NW London's acute trusts.

These clinical standards, along with the London Quality Standards and the national Seven Day Services Standards, will underpin quality within the future configuration of acute services, including along the urgent and emergency care pathway. North West London is committed to delivering seven day services across the non-elective pathway by March 2017, based on the national clinical standards, in order to improve the quality and safety of services and to support emergency care flow.

As of April 2015, all acute trusts will meet the following 7 day standards:

- Time to first consultant review: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
- On-going review: all patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate.
- Diagnostics: hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: within 1 hour for critical patients; within 12 hours for urgent patients; within 24 hours for non-urgent patients.

In addition, in 15/16 acute trusts will be expected to produce quarterly patient experience reports that compare feedback from weekday and weekend services.

Over the course of 2015/16, acute trusts will work towards achieving the following 7 day standards:

- Multi-disciplinary Team review: all emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.
- Shift handover: handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

All providers across primary, community and social care will work towards 7 day discharge pathways - i.e. that support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

The acute reconfiguration is dependent on significant take-up of existing and new out of hospital services being delivered locally by all CCGs to ensure that patients only go to hospital when they need to.

2014/15 service changes

Following the 'full' support of the Secretary of State in October 2013 following the review of the Independent Reconfiguration Panel, priority service changes are being delivered in 2014/15:

- Transition of services from the Emergency Unit at Hammersmith Hospital
- Transition of services from the A&E at Central Middlesex Hospital
- All Urgent Care Centres (UCCs) moved to a common operating specification, including a 24/7 service

The programme has also been undertaking contingency planning for the potential transition of Maternity and Paediatrics services at Ealing Hospital.

Contracts for 2015/16 will reflect the full year effect of the changes above.

OBC development

Outline Business Cases (OBCs) will be developed and centrally reviewed for all sites in 2014/15 (major and local hospitals). Additionally, the programme is also developing an Implementation Business Case (ImBC) to ensure that the refined solution for NW London remains affordable and aligned with the clinical vision. OBCs for Major and Local Hospitals are expected to be approved by NHSE, NTDA, DH and HMT in 2015/16, and following this Full Business Cases will be developed to allow the redevelopment of sites to continue.

Out of Hospital Services

Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs are working together to enable transformation within primary care across the CWHHE collaborative. Each CCG has an Out of Hospital ('OOH') strategy that describes keeping the patient at the centre of their own care, with the GP as a key provider and coordinator of services. In addition, key strategic priorities for the CCGs are to improve quality, reduce variation within primary care and ensure all patients within the CCG have equity of access to commissioned services. The CWHHE collaborative has therefore agreed to realign services to support the delivery of the OOH strategies, including the commissioning of a consistent range of services – an OOH portfolio - from GP networks. The portfolio comprises the following services:

Services	
Ambulatory Blood Pressure Monitoring	Diabetes (High Risk)
Access	Electrocardiogram
Anti-Coagulation Monitoring	Homeless
Anti-Coagulation Initiation	Near patient monitoring
Care planning	Phlebotomy
Complex common MH	Ring pessary
Complex wound care	Severe and enduring MH
Diabetes Level 1	Simple wound care
Diabetes Level 2	Spirometry Testing
Diabetes (High Risk)	Spirometry Testing

The table below describes the services to be commissioned through the Out of Hospital Services commissioning programme. The unit construction method, indicative current service impacted, and total expected activity volumes for a full year for the CCG are shown below. Please note that we do not expect a full year of activity to be transferred in 2015/16 as we will be phasing roll out. We will work with providers over the next three months to define how each provider will be impacted. Where services are predicted to meet 100% population coverage, decommissioning notices will be issued to current providers, as appropriate.

Out of Hospital Service	WL Activity Forecast (100% coverage)	Activity Type (contact or package)	Indicative Acute Point of Delivery (POD)
ABPM	4,737	Per test	Cardio OPD
Anticoagulation Monitoring	2,303	Package p.pt p.a (FA+12FU)	Clin Haem OPD
Anticoagulation Initiation	987	Package p.pt p.a (FA+8FU)	Clin Haem OPD
Case Finding, Care Planning & Case Management	4,699	Per patient	N/A
Complex Common Mental Health Management	2,238	Package p.pt p.a (FA+7FU)	N/A
Complex Wound Care	247	Per contact	Various
Diabetes (Level 1)	8,024	Package p.pt p.a (FA+2/3FU)	Diabetes OPD
Diabetes (High Risk)	4,370	Package p.pt p.a (+2appts)	Diabetes OPD

Diabetes (Level 2)	241	Package p.pt p.a (FA+2FU*)	Diabetes OPD
ECG	5,310	Per test	Cardio OPD
Homeless	5,028	Package p.pt p.a	A&E/ NEL
Near Patient Monitoring	1,081	p.pt p.a	Rheum OPD
Phlebotomy	76,735	Per venepuncture	
Ring Pessary	484	Per ring p.pt p.a	Gynae OPD
Simple Wound Care	2,475	Per contact	Various
Spirometry Testing	3,877	Per test	Respir OPD
Transfer of Care: Severe and Enduring Mental Illness	481	Package p.pt p.a	N/A

*11 appts for patients who need GLP-1 and insulin.

Mental Health Transformation

In 2015/16, CCGs wish to see continued implementation of the Shaping Healthier Lives 2012-15 core initiatives including:

- Urgent Care: roll out of the SPA and 24/7/365 access to home-based urgent assessment and initial crisis resolution work.
- Liaison Psychiatry: further benchmarking of services to drive increased standardisation of investment, activity, impact and return on investment.
- Whole Systems/Shifting Settings: building on work to date to implement primary care plus, to test, refine and roll out a new model of 'community staying well' services for people with long-term mental health needs, providing the GP (as accountable clinician) with a range of care navigation, expert primary mental health and social integration/recovery support services to deliver care closest to home and prevent avoidable referral to secondary.

In 2014/15, the Transformation Programme Board has sponsored development work streams in dementia, learning disability, perinatal mental health and IAPT. CCGs will expect providers of service to implement the key pathway, models of care and quality standards that emerge from these work programmes. Regarding CAMHS OOH, CCGs will be commissioning a new provider of service, following that service review, due to be complete early Autumn 2014.

In June 2014, the Collaboration Board supported the need for co-ordinated, system-wide change in NWL as the best way to achieve our vision for mental health and wellbeing services, ensuring mental health has an equal priority with physical health, and that those with mental health needs get the right support at the right time. It agreed that a programme of work should be delivered to address the strategic challenges and opportunities facing mental health and wellbeing services in NWL. Since then, engagement has been undertaken

with a wide group of stakeholders to gauge their interest in the programme and their views regarding its scope and the timescales within which each stage of the programme could be achieved. Stakeholders include all NWL CCGs and Local Authorities, WLMH, CNWL, Directors of Public Health, members of the Mental Health Programme Board, Lay Partners and Imperial College Health Partners.

Overall enthusiasm and commitment has been high whilst recognising the need to ensure alignment with existing local programmes and priorities and national initiatives. In September the Collaboration Board noted progress on development of the NWL Whole System Mental Health and Wellbeing Strategic Plan and endorsed a Programme Initiation Document setting out the governance arrangements, overall timetable and the resourcing requirements to deliver this exciting and important piece of work. The programme will likely commence in November 2014, with a case for continuity and change produced six months afterwards, and options for change six months after that. There may be a need for public consultation depending on which options are developed.

4.2 Whole Systems Integrated Care

In the summer of 2013, along with partner organisations across North West London (NWL), we committed to a vision to create "better coordinated care and support, empowering people to maintain independence and lead full lives as active participants in their community." The Whole Systems Integrated Care (WSIC) programme was established to achieve this shared vision. As indicated in our commissioning intentions last year, an extensive programme of co-design ran through 13/14, which included partners from health and social care organisations across NWL, service users and carers.

NWL is one of fourteen national integrated care 'Pioneers'. We are currently developing detailed local plans in order to begin implementation in 15/16 and will continue our commitment to collaboration and co-production with our partners. We anticipate that our transition to full Whole Systems Integrated Care will take three to five years, at which point we will be:

- Commissioning fully integrated models of care based on the holistic needs of different population groups, encompassing both health and social care
- Jointly commissioning for each population group a set of outcomes across health and social care, with a single, combined, capitated budget to achieve them. Through capitation, we will support service users to access a personal budget for health and social care needs as agreed through the development of a personalised care plan
- Commissioning a group of providers to offer an integrated care service to the population groups. We anticipate that these providers will work together as an accountable care partnership (ACP) and be held collectively accountable for achieving the commissioned outcomes and managing the associated financial risk for the population groups.

In 15/16, we will begin to move towards Whole Systems by implementing elements of a new model of care, employing a joint commissioning approach and continuing to work collaboratively with providers to support the development of accountable care partnerships.

All providers will continue to have the opportunity to participate in the development of WSIC through a collaborative, iterative process. Through ongoing co-production with both our partners and service users, we will continue to build towards a model of integrated care that best meets the needs of our residents. We expect providers currently working with population groups in our local area to respond to these intentions.

Whole Systems for patients aged over 75

West London CCG's key integration programme is its Putting Patients First (PPF) programme, which supports the principles of care planning, case management and multi-disciplinary working. The programme has been rolled out to all GP practices in West London and other providers are involved through regular multi-disciplinary team meetings at practice level. The principles embedded within PPF will be built upon as part of our Whole Systems programme in 15/16 to include the following key schemes:

1. Development of accountable care partnerships as colleagues from across health and social care are brought together from their parent organisations to deliver person-centred, integrated care
2. A co-ordinated health and social care team working together to provide access to reablement and rapid response services (Integrated Crisis Response/Community Independence Service programme enabled through the Better Care Fund)
3. An Older Adult Support Team, including geriatric and mental health geriatrician input, supporting case managers and carrying out domiciliary visits
4. A transformed primary care service with the skills and capacity to be central to the model of care for this cohort of patients
5. Further enhancement to the current MDT structure through development of Primary Care Navigator and Case Manager roles currently operating as part of PPF. These case managers offer continuity and pro-active case management for our complex patients and their role will be the bed rock for Whole Systems. In addition we will expand our mental health practitioner and prescribing roles to ensure complete coverage of all of our practices
6. A single point of access through a Central Coordination Team to ensure high quality provision of health and social care in the community, avoidance of unnecessary admissions and early safe discharge of patients from hospital
7. North and South Integrated Hubs would deliver the care based on what the Central Coordination Team delegates to them. They work with the individual's GP and home carers, who sit in the GP practices, and the wider multi-disciplinary team to deliver the right interventions at the right time and in the right setting
8. Self-care, community capital and the voluntary sector are core parts of the model.

Scheme 2 above has been rapidly enabled through the focus provided by the BCF. Therefore this scheme is currently the most advanced, with the business case for new investment having been signed off by our Governing Body and the Health and Wellbeing Boards. The scheme supports the development of an integrated health and social care team providing services where possible in people's own homes to keep them out of hospital and residential care. Crisis response is a key function within an older person's care pathway, so will form a key component of a Whole Systems model of care. The components which need further focus as we move forward include proactively managing patients when they are stable and supporting self-care.

In addition, scheme 3 has been worked up and a business case has been agreed which will see an Older Adult Support Team in place for winter 2014. This team will form a key function as part of a whole system in West London CCG.

Work will continue during the autumn to develop a full business case for Whole Systems, which incorporates Integrated Crisis Response/Community Independence Service and the Older Adult Support Team as key functions, but set within the context of an accountable care partnership. There will be further work to understand how these functions operate as part of a whole system which places primary care in the centre.

Whole Systems for patients with long-term mental health needs (LTMHN) - the 'Community Living Well Service'

During 2014-2015, the Mental Health Programme Board has overseen a NWL-wide programme to support development of innovative service models for people with mental health needs to 'live well' in the community, increasing their resilience and social integration, and decreasing their reliance on secondary care services. Two 'early adopter' sites exist, one of which is West London CCG (the other is Hounslow), which have been developed in partnership with the Tri-Borough Public Service Reform programme to ensure join up with key services required to support recovery.

Following significant local co-production with service users, carers, advocates, GPs, third sector and mental health professionals, a new 'Community Living Well' service model has emerged. This would be the 'first port of call' for GPs when they need support for their patients, or advice on management of their mental and physical health in an integrated primary/community-based service. Critically, it would also provide GPs and those with mental health needs who do not need secondary care with access to expertise that supports recovery and social integration, from social networks, activities and time-banking, to support with housing, employment, training, life skills, meaningful activity, housing and benefits: all the wider determinants of good mental health.

During the latter part of 2014-15, detailed process co-design will take place to determine how the model will operate. The principle of co-production, with service users at its heart, will drive this, and will be embedded as an on-going part of how the service operates. The model envisaged will be located in a community setting, with flexible access and support that 'wraps round' the needs of service users.

It is envisaged that a detailed specification of this service will be complete by March 2015 with a forward procurement and mobilisation plan in place in Quarter 1 of 2015-16.

Better Care Fund

The Better Care Fund (BCF) is a key enabler for Whole Systems Integrated Care, and is being taken forward across the Tri-borough through four major workstreams.

Two major schemes within the BCF that are particularly significant for West London are described below. These schemes represent a continuation of the direction we set out in our commissioning intentions for 2014/15; they are aimed at addressing increased demand and

complexity of need amongst older people as well as improving efficiency and reducing duplication. The schemes are:

- Transforming nursing and residential care home contracting
- The Integrated Crisis Response/Community Independence Service (ICR/CIS).

Transforming Nursing and Residential Care home contracting:

The Tri-borough CCGs and Local Authorities will develop their proposals to integrate the functions of commissioning, contracting and assuring the quality of care home placements across the three boroughs. Within Tri-borough, there is currently no consistent approach to contracting, brokerage and monitoring of placements, whether funded by Adult Social Care or health, and this results in a lack of alignment with regard to contracting, safeguarding and quality assurance resources, intelligence and expertise.

Our proposal for a single integrated commissioning team will eliminate gaps, duplication and disconnects across nursing and residential care placements by creating a consistent, joint approach to contracting, safeguarding and escalation, and oversight of the sector, as well as tailoring and focusing care around the individual.

In 2015/16 we will:

- Integrate the contracting and brokerage functions for nursing and residential care placements across adult social care and health, creating a single team. Under this arrangement, CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements
- Align the teams that undertake reviews of placements and that also gather and monitor provider data and intelligence. This will include intelligence about the quality of placements and safeguarding concerns
- Work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction.

Within the scope of this project is:

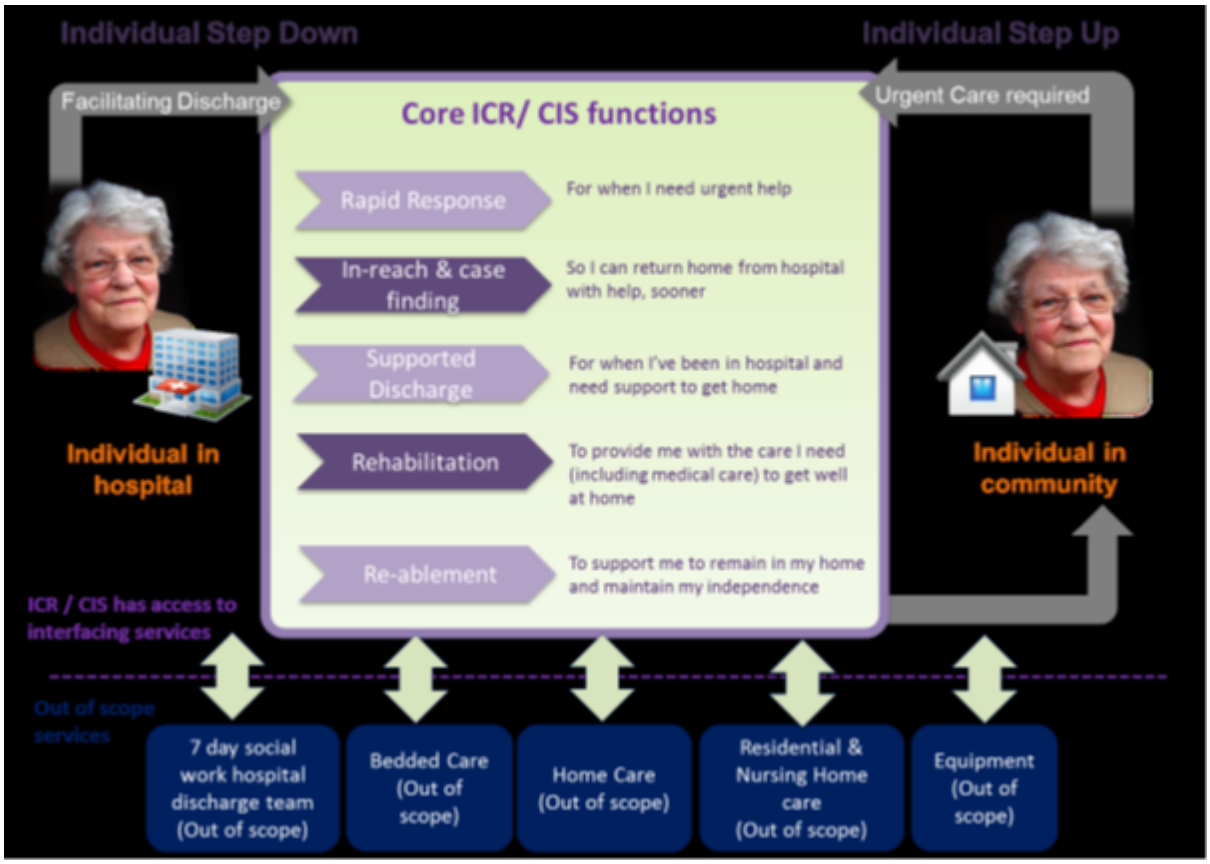
- Integration of the contracting and brokerage functions across Local Authority and Health placement teams, including:
  - Funded Nursing Care (FNC)
  - Non-residential Continuing Health care placements
  - Residential Continuing Health care placements
  - Adult Physical Disabilities placements
- Feasibility evaluation of increasing delegated authority thresholds for Continuing Health care placements
- Improved monitoring and pooled intelligence around service provision
- Qualification and quantification of potential financial savings associated with a joint contracting/brokerage team (supported by improved provider intelligence).

The Integrated Crisis Response/Integrated Community Independence Service (ICR/CIS):

The Tri-borough CCGs and Local Authorities are developing their intentions to commission a single Integrated Crisis Response/Community Independence Service. 'Integrated Crisis Response' indicates that this service responds to people with acute needs who are otherwise at risk of being admitted to hospital or a care/nursing home placement. It is also named 'Community Independence Service' to reflect the rehabilitation and reablement offer which enables people to regain their independence and remain in their own homes. The service is delivered by a multi-disciplinary team of community nurses, social workers, occupational therapists, GPs, geriatricians, mental health workers and others.

<u>What's in scope?</u>

Figure A provides a simple visual of the proposed ICR / CIS model from the patient's perspective.



A single integrated service specification for ICR/CIS starting in 2015/16 has been agreed by the CCGs and Local Authorities. This specification is for health and social care providers to work to one standard. The specification proposes an integrated, multi-disciplinary model of care that includes:

- A Single Point of Access (SPA) and referral (triage)
- 7 day a week hospital discharge services intrinsic to ICR/CIS 'case finding' and 'in reach' functions

- A rapid response multi-disciplinary team (MDT) providing community care within 2 hours and for up to 5 days
- A short term intensive intermediate community team which includes access to short term community beds reablement services for between 6 and 12 weeks
- Non-bedded community rehabilitation, treating non-complex conditions in a community setting.

The service we commission will be required to liaise with the registered GP as part of any decisions made about the patient. The Putting Patients First (PPF) case managers are the key care coordinators supporting patients whilst they are stable and also whilst they are requiring a crisis intervention.

The outcomes this will achieve are:

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

Significantly, this will mean the following differences from April 15 onwards

- Single entry point into the service
- Single assessment process
- 2 hour rapid response
- Standardised hours for all functions
- 7 day working
- Medical input across all three services
- Single set of KPIs and outcomes monitoring framework
- S113 agreements established across each of the boroughs.

Following consultation with providers and co-design with patients on the proposed model and investment for 2015/16, commissioners will further specify how they will implement the recommendation set out in the detailed business case (September 2014), that:

- The new investment of £7.4m would be packaged up and offered out to the existing set of providers, in order to appoint two lead providers (1 in social care and 1 in health) to manage the delivery of the new service. A process will be run between existing providers in order to appoint 2 lead providers who would then work together in partnership to ensure delivery of a single integrated service.

In Quarter 3 of 2014/15 commissioners will inform existing providers of the process to select the lead providers and the requirements for these providers work together under a formal

agreement during 2015/16. This process will be completed by 1st April 2015 and will be informed by our work with patients in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model.

4.3 Primary Care Transformation

A number of drivers have combined to create a pressing need to transform General Practice in NW London:

- **Patient expectations and requirements:** In a recent survey of NWL patient priorities for primary care, seven of the top ten issues related to improved access.
- **Patient needs:** The capacity of primary care is being placed under pressure. GPs are now managing more – and more complex – patient needs, including increasing numbers of patients living with long term conditions. London has many examples of great primary care and general practice. However, the service is nevertheless too variable and in places, unable to cope with the pressures placed on it today and into the future.
- **Implementation of the Shaping a Healthier Future reconfiguration programme:** The Independent Reconfiguration Panel (IRP) report on NWL's Shaping a Healthier Future (SaHF) programme requires GP practices in NW London to move towards a 'seven day' model of care to support the agreed changes to acute services.
- **Contractual drivers:** With effect from April 2014, GMS contractual arrangements have been amended to reflect an increased emphasis on improved access to General Practice.
- **Financial drivers:** A consistent, system-wide access model has the potential to reduce costs for both commissioners (reduced service duplication) and providers (more efficient use of resources).
- **Legislative changes:** The approval of the Legislative Reform (Clinical Commissioning Groups) order 2014, allows Clinical Commissioning Groups to form a joint committee when exercising their commissioning functions jointly; as well as enabling CCGs to exercise their commissioning functions jointly with NHS England via a joint committee.
- **Primary care strategic framework:** NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. In the future, they will be used to support local transformation strategies.

Though it may be part of the solution, expanding capacity alone will not sustainably improve General Practice. To deliver a new model of care that will drive a new model of General Practice, any strategy must deliver against 4 criteria:

1. **System-wide reconfiguration of access to all 'General Practice'-type services:** the provision of additional urgent appointments outside of core hours is unlikely to lead to sustainable improvements to access. In order to deliver services that genuinely reflect patient needs and preferences, we need to think about 7 day working across General Practice in its totality.
2. **Financial and operational sustainability:** a new model must be affordable and deliverable. In the long-term this probably means no net increase in cost or workforce.

3. **Meeting patient expectations:** a new model must deliver the type of appointments patients want, when they want them.
4. **Reconfigures supply and demand such that both are mapped more closely to clinical need:** Though patient choice should be respected, every effort should be made to ensure that patients receive care appropriate to their clinical condition. This means mapping capacity more closely to clinical need.

NWL have resourced a Primary Care Transformation programme to take this work forward. The programme comprises 5 distinct workstreams, which are described below:

Prime Minister's Challenge Fund (PMCF)

On 1st April 2014 this initiative was launched to improve access to general practice and test innovative ways of delivering GP services. NWL was chosen to deliver the largest pilot scheme - covering nearly 400 practices, and 1.8 million residents. This funding (matched by contributions from NWL CCGs) will be a significant enabler to delivery of NW London's vision for a transformed primary care landscape.

It is planned that the PMCF project will produce outcomes covering Urgent, Continuous and Convenient Care:

		Network responsibility	Implementation guide for 2014/15
URGENT CARE	• Patients with urgent care needs provided with a timed appointment within 4 hrs.	✓	Long term
	• Patients with non-urgent needs will be able to contact a clinician within 48hrs by phone, online or in person.	✓	Long term
	• Telephone advice and triage available 24/7 via 111.		
CONTINUITY CARE	• All individuals who would benefit from a care plan will have one.	✓	Medium term
	• Everyone who has a care plan will have a named 'care co-ordinator'.	✓	Medium term
	• GPs will work in multi-disciplinary networks.	✓	Medium term
	• Longer GP appointments for those that need them.	✓	Medium term
CONVENIENT CARE	• Access to General Practice 8am-8pm (Mon-Fri) and 6hrs/day during the weekend.	✓	Long term
	• Access to GP consultation in a time and manner convenient to the patient (via a range of channels including telephone, email and videoconference).	✓	Short term
	• Online appointment booking and e-prescriptions available at all practices.	✓	Short term
	• Patients given online access to their own records.	✓	Short term
	• Online access to self management advice, support and service signposting.		

We are doing this by supporting practices to develop strong networks and plans, so that by the end of 2014 / 2015 business cases will be available for a new model of care, and quick wins (e.g. around new applications for technology) will have been implemented. All PMCF activity is expected to align with changes in the GP contract agreement.

Primary Care Strategic Framework

NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. Further work is ongoing to refine and develop these as part of a pre-engagement phase.

The three areas are in effect a specification within a strategic commissioning framework to support local primary care transformation. This specification describes the service offer that patients could expect in the future across London, but it acknowledges implementation plans will need to be locally developed to meet the needs of different populations. In addition, it is expected that working in this way will relieve pressure and therefore enable general practice to deliver the improvements in care that they want.

It is now anticipated that these descriptors will be ready for wider engagement at the end of 2014. Our work is now focused on engaging with stakeholders and understanding how the descriptors could support a new model of care.

4.4 Patient Empowerment

As part of the wider integration agenda with Adult Social Care, we have been working in partnership with patients, carers and voluntary organisations to co-design and commission a range of patient empowerment programmes. The programmes will be targeted at supporting people with long-term conditions to take more control of their health and wellbeing. The outcome of engagement has enabled us to identify and embed an approach to working with patients, service users, carers and stakeholders. Our approach is therefore:

- **Collaborative**: bringing together clinicians, staff, patients, service users and the community together as equal partners to develop and implement the BCF programme
- **Evidence-based**: engaging to co-design evidence-based and locally appropriate solutions to promote integrated health and social care
- **Asset-based**: developing the capacity of patients, service users and the community to engage effectively in identifying needs, project planning and development, procurement, implementation and evaluation
- **Continuous and iterative**: engaging to build and refine sustainable models for local delivery that reflect the needs and aspirations of local people and frontline staff**/**

In terms of the programmes, these include:

Improving Experience of Integrated Care

The aim of this project is to monitor improvements in patient, customer and carer experience of integrated care by establishing an integrated system for capturing, using and integrating real-time patient, service user and carer experience and intelligence. The developed approach will be used to capture initial baseline intelligence of patient experience and continued monitoring of patient experience of integrated care, specifically regarding the Community Independence Service (CIS), and then eventually across wider transformation projects. This project will also support wider engagement and communications across the Better Care Fund and Whole Systems agenda by providing tools and support to facilitate effective engagement and co-design.

Embedding Self-Management

We will support patients and communities to have greater control over their health and wellbeing by co-designing a package of self-management programmes and interventions with customers. Specifically we will:

- **Commission new – and expand existing – evidence-based self-management programmes** and co-design condition specific self-management programmes to address gaps in service provision. We will do this by working in partnership with local 3rd sector organisations
- **Deliver a workforce development programme** on self-care and self-management
- **Establish a central point of contact** to provide tailored support and sign-posting in the health and social care systems, for those with long-term health conditions and their carers.

5. Required quality and outcome improvements

Quality

The CCG has identified priority areas for quality improvement in its main providers. These are detailed below.

Provider	Required quality improvements
CLCH	• Referrals responded to during the day, twilight or night periods within 24 hours • Reduction in grade 3 and 4 hospital acquired pressure ulcers.
CNWL	• Percentage of complaints agreed to within agreed targets • IAPT access: 15% of people with depression receiving psychological therapy • Recovery rate IAPT: 50% of people who complete treatment and are moving to recovery • Decreased number of violent and aggressive incidents.
Imperial	• Choose & Book: ensure sufficient appointment slots are available • Percentage of complaints agreed to within agreed targets • Decrease the percentage of cancellations by hospital for non-clinical reasons • Breastfeeding initiation rate • First booking maternity appointments completed by 12 weeks + 6 days as a percentage of total booking appointments in month, excluding late referrals (women referred after 10 weeks + 6 days).
Chelsea and Westminster	• Improvements in elective c/section rates • Palliative care patients who died in their preferred place of death.

Safeguarding

All services commissioned by the CWHHE CCGs must comply with the current legislation and NHS assurance systems covering safeguarding children and adults.

In respect of safeguarding children, services must comply with Section 11 (Children Act 2014), Working together to Safeguard Children (2013) and the current London Child Protection Procedures.

In respect of safeguarding adults, services must comply with the current London Safeguarding Policy and Procedures and be compliant ready for the Care Act 2014 which comes into force in April 2015.

Services must provide quarterly reports completed in a framework agreed with the designated nurses and adult leads and be prepared to report on their compliance with any additional statutory frameworks published during the period of the contract.

Quarterly reports must include training data, supervision provision, activity utilising partnership working, as well as a summary of learning from local and national case reviews or reports. The quality schedule is cross referenced to these points.

An annual report must be submitted to the CCG by August 1st.

Referrals to the Local Authority Designated Officer in relation to allegations against staff working with children or vulnerable adults must be reported to the Designated Nurse and Commissioner within one working day.

6. Information Technology

The CCG will continue to establish information technology across its commissioned services to ensure integrated and fit for purpose solutions that link primary care with other settings of care. For the coming year the intention is to build on the established programmes. Business Intelligence is a key enabler in all aspects of the CCGs commissioning programmes and providers will be asked to align their IT offering to achieve the overarching principle of achieving one actual or virtual electronic patient record across all settings of care.

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

- *Level 1* - There is access to and two way information exchange as well as associated workflow 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. Providers will be expected to actively consent patients when sharing their records.

The CCG has made considerable investment in ensuring a unified primary care IT platform. 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. Explicitly, the CCG will expect all staff working in community settings to use SystmOne as default clinical system and will expect providers delivering ambulatory urgent care to use SystmOne.

The overriding objective is to improve standards of care facilitated by the accurate, timely and appropriate information exchange. However, at the core will be the principle of the primacy of the primary care record and the objective to directly or indirectly achieve the outcome of one patient one integrated record.

The technology currently in place and due to be implemented during 2015-16 will bring about a turning point in how different organisations work together to provide patient centric care. The CCGs will encourage all existing and future providers to:

- Fully exploit the opportunities by the standardised and common technology platforms, engaging staff to collaboratively design and implement solutions that bring about improvements in diagnosis, treatment and longer term care.
- Implement work and information flows that will reduce the administrative and processing burden on clinical and administrative staff across different organisations.
- Ensure that information exchange is in real time, processed within native IT systems of the organisation, accurate in content, structure and coding at the point of data entry.
- Inform and enable 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.

It is a key objective to enable patient access to a suite of online services as well as their own records within a robust and secure environment. Under the Prime Minister's Challenge fund programme GP practices have been and will continue to provide patients access to their online services. Providers outside of primary care will also be asked to develop or link with existing systems so that patients have greater access to wider online services and records.

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

- Continue working to improve the timeliness and quality of information sent to or accessible by providers from GP practices via clinical IT systems and to ensure the most up to date, relevant and accurate information is always sent.
- Continue working with providers to enable safer and more efficient electronic methods of communication between them and primary care, building on the previous work and solutions around CQUINs with a greater emphasis on structured coding and integrated workflow.

- Extending the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London. Embedding the access to pathology and radiology results across all settings of care. Ensuring that ordering tests and receiving results across NW London are exclusively done electronically with minimal manual or paper based processes.
- Within the Better Care Fund programme, work with social services to develop an interface between IT systems and more robust information exchange within common information governance frameworks. Principally that all non-healthcare providers use the NHS number as the unique identifier of the patient for all services in order to integrate records.
- Developing tools for GP clinical IT systems to provide integrated services 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, national and regional strategic IT systems such as:

- Choose and Book and its replacement system e-Referrals
- Ensuring high utilisation of the Electronic Prescribing System
- Close integration and information flows with Coordinate my Care system
- Maintain the high availability of accurate and timely Summary Care Record.

7. Local pathway priorities, gaps in service delivery and improving outcomes

Minor Surgery

The CCG is currently reviewing current minor surgery services commissioned from primary care and assessing scope for further development.

Learning Disabilities

For those with learning disabilities and their families, following on from the Winterbourne View Concordat, commissioning will be taking account of the national guidance (to be published later in the financial year) from the recently established Joint Improvement Programme and NHS England National Expert and Advisory Group.

To best support people with learning disabilities at home and in their communities, and reduce the reliance on hospital care, the design of services will be done in co-production with NHS providers, Local Authorities, charities and social enterprises.

Ensuring integrated local healthcare and housing provision takes account of the impact on primary and social care capacity following the reduction in the number of adult mental health beds across localities, commissioners will be particularly focused on commissioning pathways that take account of people with a learning disability and significant mental health need (dual diagnosis).

The 2015/16 commissioning priorities will focus on all mental health pathways at crisis, assessment, treatment and staying well stages, ensuring each pathway clearly determines, articulates and accommodates where and what reasonable adjustments in care are being made and delivered for those people with learning disabilities.

Working closely with Local Authorities on market development and service specifications, providers will be required to demonstrate that:

- Service users and their carers are able to receive an appropriate level of support in relation to day service provision, employment, housing, respite care, etc within their local communities.
- Services will significantly reduce the impact on secondary care provision.
- Services enable people with learning disabilities to be cared for and/or live independently within their local communities.
- The physical and financial resources in place are appropriate in terms of capacity and skills and competencies. And, that those resources are flexible enough to meet the needs of the individual i.e. by offering a high quality, value for money range of services e.g. in-reach services, supported living schemes, etc.

In addition, commissioners will be working to improve the ways in which people with learning disabilities are able to engage in providing feedback about services. Specifically, this will mean:

- Embedding learning disability into existing engagement processes by making them fully accessible, or providing a forum for people with learning disabilities to be fully engaged in developing and improving access to mainstream health and reducing health inequalities.
- Ensuring that we are able to collect feedback on the experience of patients with learning disabilities in an accessible format.
- Rolling out accessible devices to capture the experience of people with learning disabilities in primary, acute and community health care settings
- Working with people with learning disabilities, their carers and other partners across the statutory and third sector to improve access to equitable healthcare.

Carers

The CCG will continue to invest in services for carers, building on the work done in 2014/15, which has included the development of primary care based support for carers and for young carers.

As part of its Equality Objectives for 2013-2017, the CCG has committed to improving 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 Care and Support Act, which outlines the need to provide support services to carers, rather than simply identifying their needs.

Young Carers

We will continue to maintain our investment in supporting carers, with support to young carers as a key priority. We recognise the importance of working closely with partners and with organisations beyond health and social care, including education, in order to continue identifying and supporting carers.This will include a family based approach to support carers and their families to improve access to health care and reduce health inequalities.

The CCG will improve the rates of identification of young carers through primary and acute care.

8. Procurement plans

A summary of our specific procurement plans are set out in the table below and anticipated 'go live' dates are included in brackets.

Services where procurement is initiated in 2014/15 but there will be impact in 2015/16	**Services being procured in 2015/16**
111 (October 2015)	
Chel West UCC (October 2015)	
Expert Patient Programme (April 2015)	
Diagnostics (April 2015)	
Dermatology (April 2015)	
Cardiology (April 2015)	
Respiratory (April 2015)	
Ophthalmology (July 2015)	
Mental health service user group (Q1 2015/16)	
Wheelchairs (October 2015)	
Face to face interpreting services (Q2 2015/16)	

Providers should note that the St Charles Urgent Care Centre and GP Out of Hours contracts are under review and may be subject to procurement exercises later in 2014/15 or in 2015/16. The Out of Hours CAMHS service is under review in 2014/15 and may be subject to a tender exercise in 2015/16.

9. Contracting Intentions

Whole Systems Integrated Care (including Better Care Fund work-streams)			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
New models of care in place for early adopters for over 75s and people with long-term mental health needs	<u>Whole Systems for patients aged over 75</u> In 2015/16, health and social care commissioners will hold multi-provider accountable care partnerships to account for delivery of population health outcomes for this population group. We will be co-commissioning an accountable care provider to commence during 2015/16 to deliver the range of services below: • 7 day services and a 24/7 over 75 primary care crisis response service. • Enhanced primary care service for over 75s • Outreach acute services working as part of a local community hub. There will be an underpinning principle of moving from unplanned to planned care for our over 75 population. A commitment will be expected from all providers to work differently within the umbrella contract for Whole Systems. Shadow capitated budgets will be in place and will be monitored for this patient cohort. The intended impact is to reduce hospital unplanned demand and the sizing of the above services will be quantified during analytical modelling by December 2014	Westminster City Council and the Royal Borough of Kensington and Chelsea	Acute, community, primary care, mental health, social care, GP out of hours, London Ambulance, third sector

	and will influence the final requirements of new services. <u>Whole Systems for patients with long-term mental health needs</u> In 2015/16, health and social care commissioners will hold multi-provider accountable care partnerships to account for delivery of population health outcomes for this population group. We will be co-commissioning an accountable care provider to commence during 2015/16 to deliver the range of services below: • Support for GPs in the management patients with long-term mental health needs • Access to expertise that supports recovery and social integration, from social networks, activities and time-banking, to support with housing, employment, training, life skills, meaningful activity, housing and benefits There will be an underpinning principle of supporting people with mental health needs to 'live well' in the community, increasing their resilience and social integration, and decreasing their reliance on secondary care services. A commitment will be expected from all providers to work differently within the umbrella contract for Whole Systems. Shadow capitated budgets will be in place and will be monitored for this patient cohort. It is envisaged that a detailed specification for this service will be complete by March 2015 with a forward procurement and mobilisation plan in place in Quarter 1		

	of 2015-16.		
Implement new Community Independence Service model	As part of the Better Care Fund, the implementation of a Tri-borough Integrated Community Independence Service will commence in 2015/16 with a transition year during which a phased approach can be taken with existing providers to work to a new single model service specification. Following consultation with providers and co-design with patients on the proposed model and investment for 2015/16, commissioners will further specify how they will implement the recommendation set out in the detailed business case (September 2014), that: • The new investment of £7.4m would be packaged up and offered out to the existing set of providers, in order to appoint two lead providers (1 in social care and 1 in health) to manage the delivery of the new service. A process will be run between existing providers in order to appoint 2 lead providers who would then work together in partnership to ensure delivery of a single integrated service. In Quarter 3 of 2014/15, commissioners will inform existing providers of the process to select the lead providers and the requirements for these providers work together under a formal agreement during 2015/16. This process will be completed by 1st April 2015 and will be informed by our work with patients in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model. The lead provider(s) will need to demonstrate how they will ensure:	Hammersmith and Fulham CCG, Central London CCG and the Tri-borough local authorities	Community trusts, mental health trusts, acute trusts and social care providers

	• A rapid response multidisciplinary team (MDT) providing community care within 2 hours and for up to 5 days • Non-bedded community rehabilitation, treating non-complex conditions in a community setting. • Integrated reablement with access to short term community beds between 6 and 12 weeks • 7 day support to help people leave hospital.		
Develop and embed the Older Adult Support Team as part of the Community Independence Service model	As part of the CCG's in-year development work with the Community Independence Service, a pilot Older Adult Support Team will be developed in the north and the south of West London for implementation in December 2014 with a view to formally contracting this for the full year effect 2015/16. The pilot service will be provided by Chelsea and Westminster in the south and Imperial in the north, with input to both pilots from CNWL. The teams, led by consultant physicians, will provide: • Proactive care: case management support to practice MDTs and care homes • Reactive care: support for patients requiring step up care • Training and education: CIS/Rapid Response/discharge teams, care homes, primary care, LAS Outcomes in the specification for this service will be: • To maximise care and support in a person's own home so they can live independently for as long as possible • To maintain people in an appropriate setting when in an acute crisis and when on a stable platform • To assist with ensuring A&E and UCC visits and non-elective admissions are appropriate, and to reduce hospital length of stay	West London CCG only	Acute, mental health and community providers

	• To improve complex case management, case review and consultation within a MDT setting • To provide case specific education and training • To provide specialist input to the development of community provider networks.		
Putting Patients First: patients at risk of hospital admission to have a care plan in place and case management where appropriate	The CCG will continue to commission GP practices to deliver care planning for patients at-risk of hospital admission (via the CWHHE care planning Out of Hospital contract) and this will continue to be central to our Whole Systems model. Multi-disciplinary team working will continue to be embedded in all GP practices, and all practices will have practice-facing community nursing teams and case managers, offering continuity and case management for those who need it. A cohort of case managers are currently provided by CLCH. This service is currently being reviewed as part of a SDIP and the findings of this may inform a revised role description for these case managers going forward. We will develop multi-disciplinary case management roles to ensure that patients are case managed by the professional most appropriate to their needs. Implications of this are as follows: • Additional mental health case managers will need to be identified, to ensure complete coverage • Social workers will continue to attend MDTs in practices • We will also commission pharmacists to attend multi-disciplinary team meetings and undertake home visits via Brent CCG (hosting prescribing team). We will continue to commission Primary Care Navigators to support older patients with complex needs and to	West London CCG only	Primary care, community, mental health, third sector and social care providers

	ensure the content of care plans is meaningful to patients.		
Transforming nursing and care home contracting	Enhanced primary care provision in care homes will be ensured through the delivery of Out of Hospital specifications. Most significantly, the care planning and case management specification which will ensure appropriate care planning is taking place. We will continue to roll out the ICP Care Home Innovation Project to ensure complete coverage of all our care homes. This will require pharmacists, physiotherapists, GPs and district nurses to regularly attend MDTs in care homes. This work will support a reduction in non-elective admissions and A&E/UCC attendances from care homes, which will impact acute providers. In 2015/16, as part of the Better Care Fund, we will: • Integrate the contracting and brokerage functions for nursing and residential care placements across adult social care and health, creating a single team. Under this arrangement CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements • Align the teams that undertake reviews of placements and that also gather and monitor provider data and intelligence. This will include intelligence about the quality of placements and safeguarding concerns • Work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction.	Hammersmith and Fulham CCG, Central London CCG and the Tri-borough local authorities	Nursing and care home providers, primary care, social care providers and community and acute trusts
Support the implementation of the new Tri-	Contracts with the new home care providers will be held	Hammersmith and	To be confirmed

borough Homecare service which includes the provision of low level health tasks (procurement is being led by the Tri-borough Local Authorities)	by the Tri-borough Local Authorities. The requirements to provide clinical training and governance under the new model of care will be advised. Further information on the impact of re-provision of low level health tasks will follow.	Fulham CCG, Central London CCG and the Tri-borough local authorities	
Extend the provision of neuro-rehab and intermediate care beds	For intermediate care, benchmarking and Tri-borough needs analysis work has been undertaken in 2014/15. This indicates that an increase in step up intermediate care beds, including neuro rehabilitation bedded capacity, is likely to be needed across the Tri-borough in order to meet the national average and deliver sustainable provision. We will complete the necessary detailed work to progress this and understand fully the implications in terms of dedicated medical support, enhanced nursing care provision and quick access to diagnostics, as well as financial and activity modelling to underpin future requirements.	Hammersmith and Fulham CCG, Central London CCG and the Tri-borough local authorities	Acute, community and social care providers

Patient Empowerment			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Strengthen self-management and patient education	<u>The Better Care Fund</u> The Better Care Fund Self-Management Work-stream will commission various projects under a framework for self-management transformation, including: • Workforce training and development • Capacity-building for existing self-management programmes • Process development to support transformation. The project will coordinate existing self-management transformation but also commission services that are not currently being delivered under the above framework. The details of these commissioning intentions are still being developed, in collaboration with other relevant project leads. In 2015/16 all providers will be expected to: • Train staff in motivational interviewing and patient activation models • Support design and enable access to self-care websites • Refer patient to self-care programmes. <u>Other CCG work-streams</u> The CCG is commissioning PPE grants to support self-management in 2014/15 and the successful projects will continue to run into 2015/16. The CCG is commissioning a health mentoring scheme in 2014/15, which is anticipated to extend into 2015/16. We will commission the Expert Patient Programme for	Central London CCG, Hammersmith and Fulham CCG and Tri-borough local authorities	All providers

	the Tri-borough in 2014/15 and this will be mobilised in 2015/16. We will continue to commission Primary Care Navigators in 2015/16 and will explore opportunities to maximise their role in supporting older patients with complex needs.		
Enhance methods of capturing and acting on patient feedback	<u>The Better Care Fund</u> As part of the Better Care Fund Patient Experience Work-stream, we plan to commission an organisation or agency within the next financial year to: • Co-design an approach for capturing experience of integrated care • Collect baseline data on patient experience before the implementation of the Community Independence Service • Collect comparative data during and after the implementation of the Community Independence Service • Embed a sustainable approach to capturing experience of integrated care to be used across BCF schemes. The principle commissioned organisation will be responsible for sub-commissioning support from local and voluntary authorities. In 2015/16 all providers will be expected to: • Ensure access to real time patient feedback on their experience of integrated care • Evidence action planning in response to patient experience data capture • Ensure provision of information and presentation of data which reflects the diversity of our population.	Central London CCG, Hammersmith and Fulham CCG and Tri-borough local authorities	All providers

	Other CCG work-streams The CCG will continue to support GP practices to establish and maintain Patient Participation Groups in 2015/16. We will re-commission the mental health service user group for the Tri-borough in 2014/15 and this will be mobilised in 2015/16.		
Expand coverage of Personal Health Budgets	During 2015/16 we will to increase the take up of Personal Health Budgets by providing greater support to people who wish to have a Personal Health Budget and making them available to a wider range of people. Continuing Healthcare Personal Health Budgets Personal Health Budgets will continue to be offered to everyone who is eligible for Continuing Healthcare in all care groups. Mental Health Personal Health Budgets We will complete the mental health pilot with WLCCG and Kensington and Chelsea MIND and, in line with 2015 guidance on Personal Health Budgets and mental health, aim to make these available for certain groups of people. Long Term Conditions Personal Health Budgets Personal health budgets will be offered to people who have long-term conditions across a range of health conditions. We will undertake a pilot for LTC and publish our offer from April 2015. We will develop this offer initially around therapies. We will review all relevant contracts to determine areas which are 'cashable' and can be used to provide services in a different way. This may be through 'top slicing' a small percentage of contract value in order to use the money differently.	Central London CCG, Hammersmith and Fulham CCG and Tri-borough local authorities	Community services, social care providers and third sector

	Children's Personal Health Budgets We will continue to work with our Local Authority partners to implement the Children and Family Act 2014 and in particular, new undertakings in relation to Personal Health Budgets. This will include sign posting eligible children, young people and families and ensuring Personal Health Budgets are considered as part of the Continuing Healthcare plans.		

Primary Care Transformation			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Deliver population-wide access to Out of Hospital services in general practices	The CCGs in the CWHHE collaborative are working together to enable transformation within primary care. The CCGs have agreed to realign services to support the delivery of the Out of Hospital strategies, including the commissioning of a consistent range of services – an Out of Hospital services portfolio - from GP federation(s). The portfolio comprises the following services: <u>Group 1: primary care services which will not result in reduced activity in other providers</u> Primary care access Care planning Complex common mental health Diabetes level 1 and diabetes high risk Homeless <u>Group 2: services which, when fully established in primary care, will reduce the amount of activity in other settings</u> Anti-coagulation monitoring Anti-coagulation initiation Simple wound care Complex wound care Diabetes level 2 Near patient monitoring Phlebotomy Severe and enduring mental health Ring pessary Ambulatory Blood Pressure Monitoring*	CWHHE CCGs	Primary care, acute providers, mental health providers and community providers

	ECG* Spirometry Testing* At this stage, the impact on individual acute, community and mental health providers is yet to be fully confirmed, as the new GP federation(s) are in the process of confirming contracted services and activity levels. It is also recognised that the implementation of these services will have varying impact as some are new, whilst others represent an extension of existing services, both in terms of specification and population coverage. In 2015/16, the roll-out of the service portfolio will be completed with the aim to have full population coverage by 2016/17. *Community providers have already been given notice that community cardiology and respiratory services are being tendered by the CCG in 2014/15. Some direct access diagnostics activity will be delivered under the new community contracts during 2015/16, but the CCG expects that as GP federations become established, the majority of this work will be done in primary care.		
Deliver Prime Minister's Challenge Fund objectives	We will commission primary care to deliver the objectives in the Prime Minister's Challenge Fund. These will include: • 7 day primary care services to be in operation within federation(s) • A range of consultation methods to be available to practices (telephone/email/Skype) • Alternative appointment booking methods to be available in primary care (ie online booking) • Patients to be able to access their records online.	NWL CCGs	Primary care

Mental Health Transformation			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Improve dementia services and achieve nationally mandated targets	The NWL Mental Health Programme Board is undertaking a review of dementia services; this review will be reporting later in 2014/15 and in 2015/16 we will be implementing the recommendations. These are likely to include creating a pathway which: • Increases capability to diagnose dementia in primary care • Increases specialisation of secondary care services to cover complex diagnosis • Increases the scope of practitioners working at the primary/secondary interface • Strengthens post-diagnosis support services including advocacy and advice services The CCG will be continuing to work to achieve the nationally mandated dementia diagnosis target.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Primary care, mental health trusts and third sector
Increase Access to Psychological Therapies and achieve nationally mandated targets	The NHS England operating plan in 2014/15 mandates the following standards: • 15% of patients with common mental illness to enter treatment in IAPT services • 50% of patients reach recovery Providers will be expected to sustain performance at or above these levels in 2015/16. West London CCG has commissioned additional capacity to meet this requirement in 2014/15. Work is currently underway to review and benchmark provision across NWL. The recommendations of this review are expected later in 2014/15 and will be implemented in 2015/16. This is likely to include procurement to increase the diversity of provision and extend services to include young people, long-term conditions, medically unexplained symptoms (MUS) and severe and enduring mental health problems.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts

Shifting Settings of Care: support people with mental health problems to be seen closer to home	We will continue to support people with mental health problems to be seen closer to home and in a less stigmatised setting. Primary care service provision will be enhanced. Provision will be designed and delivered by appropriately skilled local multidisciplinary teams and resources, working collaboratively across and between secondary, primary and third sector organisational and geographical boundaries with service users and their families and carers at the heart of decision making. To stimulate new ways of working that allows a remodelling of the workforce, and to enable the shifting of care closer to home to be achieved on a larger scale and in a consistent way, a range of resources, incentives and information will be proactively deployed and monitored to establish how providers impact directly or indirectly on quality outcomes and system flows e.g. [including but not exclusive to]: • A reduction in the burden on secondary care – delivering segments of mental health care pathways in community settings and close to patient's homes (e.g. recovery housing provision). • Prevention of patient's illness and injury, and improvements in independent living. We will also seek to repatriate out of area activity where appropriate to local providers reducing spot-purchase costs.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts, primary care and third sector
Urgent care service development to ensure that everyone who need it has timely access to evidence-based care	Building on the parity of esteem agenda, and in response to the Crisis Concordat 2014, we will work with providers to implement a value-for-money, 24/7 single point of access to urgent and emergency mental health services. This will provide rapid access to appropriate service, including crisis response, Assessment and Brief Treatment, home treatment and signposting to relevant services.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts, primary care and third sector

	We will contract with providers to ensure treatment of mental health emergencies has the same importance as a physical health emergency. We will review services to reduce the likelihood of future crisis through multi-agency recovery focused post crisis support. During 2015-2016, commissioners will contract with providers to: • Implement expediently any remaining performance improvement to deliver the NWL MH access standards for achievement by end of Quarter 1 (where necessary). • Contract for a quality improvement trajectory in terms of key Shared Care communication paperwork (MH2 – MH5.3, including those specifically tested under the Urgent Care and Access CQUIN: MH3, MH5.1 and MH5.3), for achievement by end of Quarter 1 (where necessary). • Ensure that the needs of a range of currently under-served groups are met, such as the needs of those in transition from CAMHS, those with Personality Disorder and those with severe behavioural disorders. • Address workforce development by delivering relevant training to support clinical pathways and develop core skills and competencies to enable the CCG to deliver high quality services. • Utilise developments in electronic e-referral systems and 'intelligence sharing' to enable trusted assessment across teams, improved access to treatment, faster response times and 'improved local health record self -ownership'.		
Continued implementation of psychiatric liaison standards	Specifically, in 2015/16, commissioners will be seeking to: • Secure full roll out of, and reporting against, the developmental measures being piloted by	NWL CCGs	Mental health trusts and acute trusts

	CNWL under the 2014-15 quality dashboard relating to patient experience, clinical outcomes and referrer experience. • Achieve greater core standardisation of services across all sites in terms of workforce skills mix, costs, activity, impact and productivity in line with contractual requirements. • Obtain further commissioning and delivery clarity on the nature of services across sites and, where there is a significant on-going psychological therapy provided for those with Long Term Conditions, ensure synergy with IAPT commissioning and delivery. We will require providers to work with us to understand the impact of changes in urgent care and IAPT current provision on Psychiatric Liaison Services. A review of Liaison Psychiatry Services has taken place across NWL during 2014/15 and as part of that it is the intention in 2015/16 that the Liaison Psychiatry Service in mainstream acute ward settings (not A&E) will be fully funded through the PbR Tariff. The CCGs expect the acute trusts to continue to provide a comprehensive in-patient Liaison Psychiatry Service to ensure the safety and appropriate referral of these patients to the relevant service. The provision of any additional physical care required due to a patient's mental health is included in the Admitted Patient Care PbR Tariff, although the treatment of their mental health condition is not and the patients would need to be referred to a mental health provider in the normal way through the Liaison Psychiatry Service. In addition, if an acute trust is caring for a patient with a mental health comorbidity /complication (e.g. dementia)		

	then whilst the Trust may sub-contract the care from a specialist mental health provider the Trust will be funded for this through the complications /comorbidities tariff. The CCGs will expect this to be fully operational from 1 April 2015 and will be seeking assurance through the contracting round that both the operational and business arrangements between the Trust and any sub-contractor have been agreed to the mutual satisfaction of both parties.		
Improve perinatal mental health services	We will commission services based on the recommendations of the review that is being undertaken in 2014/15. This is likely to include: • Services for all women who may experience a common mental illness (anxiety and depression) during pregnancy as well as those with a known MH problem or those who develop severe mental illness, which can be accessed to perinatal MH services for GPs and community health professionals. • Specialist perinatal services for all women with MH needs, incorporating MH midwives, and specialist MH nurses working with community midwifery teams and health visitors. • GPs to have access to a service to get specialist advice from and refer when required. • Commissioning third sector involvement to support families.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts and third sector
Improve suicide prevention services	In 2015/16 we will consider commissioning a suicide awareness and intervention training programme for multi-sector providers.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts and third sector

Children's Services			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Deliver integrated hubs for children	We will evaluate the success of the existing Connecting Care for Children hubs and consider wider roll out in 2015/16. Subject to evaluation, the CCG may look to extend the hubs to 50% of all practices in 2015/16.	West London CCG only	Acute, community and primary care providers
Commission child-centred Child and Adolescent Mental Health Services (CAMHS)	Intentions will be informed by guidance and specifications published by a number of NHS England CAMHS Clinical Reference Groups specifically focused on complex pathways i.e. Tier 4, Deaf Services, Secure Services and psychological therapies. In addition, services will be commissioned in the context of the outputs and recommendations associated with the Healthcare Select Committee Enquiry, with opportunities for commissioning alliances with NHS England explored in earnest. Following local community CAMHS reviews and working closely with stakeholders, commissioners will look to: • Jointly commission Behavioural Support Teams for children and adolescents with learning disabilities • Improve out-of-hours crisis response times and service provision • Jointly commission training and public education programmes with public health partners and safeguarding boards • Deliver equitable access to sustainable, high quality, productive and efficient CAMHS services, wherever a service user resides in North West London • Through multiagency collaboration, streamline the pathway for looked-after children in mental health.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Mental health trusts

	The Out of Hours CAMHS contract is being reviewed in 2014/15 and may be subject to a tender exercise in 2015/16.		
Deliver improvements to maternity services	We will implement the recommendations from Shaping a Healthier Future for maternity services, including: 1. Consolidation of maternity and neonatal services from seven to six sites to provide comprehensive obstetric and midwife-led delivery care and neonatal care. 2. Consolidation of paediatric inpatient services from six sites to five sites to incorporate paediatric emergency care, inpatients and short stay /ambulatory facilities. The key trusts for these services will be Chelsea and Westminster, Hillingdon, Northwest London Hospital Trust, Imperial and West Middlesex. To support the delivery of this transition a central booking system will be implemented to co-ordinate the booking process across the receiving sites.	NWL CCGs	Acute trusts
Deliver improvements in Speech and Language services	We will implement the outcomes of the service specification review for Speech and Language Therapy.	Westminster City Council and the Royal Borough of Kensington and Chelsea	Community trusts
Implementation of Children and Families Act 2014	We will implement changes required as a result of the Children and Families Act (including personal health budgets). These will include: • Signposting families to the local authority 'local offer' website which summarises Education, Health and Care service available for young people with Special Educational Needs (SEN) and disabilities • Continuing to commission local child development services to provide timely health assessments for Education, Health & Care Plans	Westminster City Council and the Royal Borough of Kensington and Chelsea	Community and social care providers

	• Collaborating with our local authority partners to deliver Personal Health Budgets' and joint commissioned services for young people with SEN and disability needs.		

Urgent Care			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Full year impact of changes to Hammersmith Hospital and Central Middlesex EDs	Full year effect of new 24/7 UCC at Hammersmith. Reflect full year effect of activity transfers to other hospitals.	NWL CCGs	Acute providers
Deliver agreed standards for 7 day working	Over the course of 2015/16, acute trusts will work towards achieving the following 7 day standards: • Multi-disciplinary Team review: all emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours • Shift handover: handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week. All providers across primary, community and social care will work towards 7 day discharge pathways. This means that support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.	CWHHE Collaborative	Acute, community and mental health providers

Design and commission an integrated urgent care system to support patients to access the right care at the right time	We will commence a procurement exercise for the Chelsea and Westminster and Imperial Urgent Care Centres during 2014/15, with a view to contract award and mobilisation taking place in October 2015/16. Existing Urgent Care Centre contracts are expected to be operating in line with the Shaping a Healthier Future specification by March 2015.	Central London CCG and Hammersmith and Fulham CCG	Acute, community and GP Out of Hours providers
	We will re-commission the NHS 111 service. The procurement exercise will commence in 2014/15 and contract award and mobilisation will happen in 2015/16, in time for service launch of October 2015.	North West London CCGs	NHS 111 providers
	We will review the Urgent Care Centre contract at St Charles during 2014/15, with a view to designing an integrated and streamlined model of urgent care at the St Charles site. This may involve a procurement process.	West London CCG only	Community and GP Out of Hours providers
	We will review the GP Out of Hours service during 2014/15, with a view to designing a service that is integrated with the rest of the local urgent care system. This may involve a procurement process.	Hammersmith and Fulham and Central London CCGs	GP Out of Hours providers
	Along with other CCGs in NWL, we will consider use of MCAP across the West London health economy to ensure effective use of healthcare resources to best support and respond to patients' needs.	NWL CCGs	Acute and community providers

Planned Care			
Key deliverable	**Contracting intention**	**Joint commissioners**	**Sectors impacted**
Design and commission planned care services closer to home	We will procure a community ophthalmology service for the Tri-borough during 2014/15, with mobilisation and activity impact in 2015/16. 30% of first appointments and 50% of follow up appointments are expected to transfer from Imperial and Chelsea and Westminster into the community in 2015/16, with effect from July 2015. Acute trusts will be expected to discharge patients back into the community service for follow up where clinically appropriate. The new community service is due to be launched in July 2015. We will identify new NICE approved ophthalmology treatments and the options that can be used for secondary care ophthalmology treatments i.e. Wet AMD that will create significant cost efficiencies and improve patient experience. Current analysis indicates upper quartile levels of spend on high cost ophthalmology drugs within secondary care with additional management on-cost charges.	Central London CCG and Hammersmith and Fulham CCG	Acute and community providers
	We will procure respiratory and cardiology community services during 2014/15, with mobilisation and activity impact in 2015/16. The new community services are due to be launched in April 2015. Notice has already been served to Imperial (community cardiology) and CLCH (community COPD/respiratory and heart failure nursing). The CCG will reduce cardiology and respiratory outpatient first and follow up activity by 70% at Imperial, Chelsea and Westminster and The Royal Brompton to	Central London CCG	Acute and community providers

	reflect the shift into community. NB this is a joint procurement with Central London CCG, and Central London expect the activity shift to be up to 80%.		
	We will continue to progress the procurement of a community dermatology service in 2014/15 and the new service is due to commence in April 2015. Our current estimate is that a further 30% of first appointments and follow up appointments would be expected to transfer from Imperial and Chelsea and Westminster into the community in 2015/16. Notice has already been served to the incumbent community service provider.	Central London CCG	Acute and community providers
	We will scope opportunities to design and procure community services for gynaecology and urology in 2015/16.	To be confirmed	Acute and community providers
	We will explore enhancing the existing MSK community service by extending it to include an integrated rheumatology pathway in 2014/15. Our current estimate is that 40% of acute activity from Chelsea and Westminster and Imperial may be expected to transfer into the community in 2014/15 with a further 10% shift in 2015/16. We will fully implement the recommendations of the CWHHE MSK Review in 2015/16	West London CCG only	Acute and community providers
	We will conclude our review of our diabetes community service pathway with a view to standardising services across CWHHE.	CWHHE CCGs	Community providers
	We are jointly re-procuring a diagnostics service in 2014/15 to commence in April 2015. As is currently the case, the activity to be delivered through the contract is on the basis of no volume guarantees. Notice has	NWL CCGs	Diagnostics providers

	already been served to the incumbent provider.		
	We are continuing to jointly re-procure a wheelchairs service in 2014/15 and expect the new service to be live by October 2015. Notice has been served to the existing provider.	NWL CCGs and Barnet CCG	Wheelchair providers

10. Equalities and engagement

Duty to Involve

West London CCG is mindful of its individual participation duty to ensure that we commission services which promote the involvement of patients across the full spectrum of prevention or diagnosis, care planning, treatment and care management. In discharging its duty, the CCG has been working in partnership with patients, carers, the wider public and local partners to ensure that the services that are commissioned are responsive to the needs of the population.

Our Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders. It requires commissioned providers to ensure that patients, service users and carers are provided with opportunities to be involved in shaping and influencing the service and the organisation as a whole.

We therefore expect that providers will provide evidence of engagement of their service users and carers in the planning, development and delivery of services. More specifically, we expect that providers:

- Train and support service users and carers to be effectively engaged in the design and delivery of services as well as in shaping and influencing the organisation as a whole
- Work with local voluntary organisations and patient groups to deliver a programme of staff training and capacity development relating to understanding the experience of specific groups and communities
- Ensure that feedback on services reflects the diversity of the patient and service user population
- Work in partnership with local health and social care organisations to capture experience of integrated care.

Promoting equalities and improving patient experience and access

We expect providers to measure patient, service user and carer experience of accessing services and demonstrate that commissioned services are accessible by all. Evidence of this will be demonstrated by the provision of evidence in the following areas:

- Patient experience data. This should incorporate data relating to key equality groups. More specifically, data should include ONS categories plus sub-categories in order to reflect the diversity of the local population. The data should be analysed to assess whether:
    - There is a difference in outcomes of experience by patients, service users and carers
    - There is a difference in the perception of treatment and care between patients, service users and carers from different equality groups
    - Action has taken place to address gaps in relation to the points above.

- Uptake and Use of services. Providers should assess whether:
    - There are differences in the frequency of usage by different equalities groups e.g. A&E and UCCs
    - The services are delivered to meet the needs of the diverse population
    - There is anything the service can do to increase usage by those groups that under-use the service
    - Action has taken place to address gaps in relation to the points above.

- Complaints and other feedback. Providers should assess whether:
    - There are differences in the complaint rates for different groups with different needs or circumstances
    - There are particular areas of the service that causes a problem for particular groups of patients, service users and carers
    - There is an underlying cause or barrier that means that certain groups are receiving a better service than others and
    - Whether or not different groups have different expectations of the service
    - For investigated complaints equalities monitoring is carried out on a sampling basis by the Complaints Team and reported quarterly.

- Children with disabilities. Providers should ensure that they have in place a range of facilities and support available to children with disabilities and their carers. More specifically:
    - Waiting areas should sensitive to the needs of disabled children
    - Changing places and toilets for complex needs children which incorporate the right equipment with enough space
    - Signposting to support groups and coping strategies offered at point of diagnosis
    - Facilities for complex needs children admitted to hospital wards should include adequate hoists and changing facilities as well as adequate food and nutrition e.g. pureed food.
    - Parents and GPs should be copied in on all doctors and therapist reports.

Responding to local needs

The Contracting Intentions table details our specific intentions for 2015/16. The CCG's plans directly respond to patient and public feedback and equalities issues within the CCG. For example, we know that patients in specific communities (such as BME communities) are not accessing psychological therapies services in proportion to their needs. Our continued investment in psychological therapies services through the Primary Care Mental Health Service, alongside targeted engagement with these communities, will help to ensure that these needs are addressed.

In addition, we are continuing to commission the Primary Care Navigator programme to support older and vulnerable patients to navigate health services and to ensure their care is integrated and person-centred.

Our PPG grants programme has allowed us to commission projects from third sector organisations to support seldom-heard groups. Examples include: dementia volunteering; health representatives project for people with learning disabilities; health access for BME people with long term conditions; Reach Programme for young people and access to health care; and our Healthy Lifestyles Programme for BME communities in the Queens Park and Paddington area. We will be commissioning further projects through this mechanism in the autumn of 2014, for projects to run into 2015/16.