NHS
Warwickshire North
Clinical Commissioning Group

Commissioning Intentions – 2014/15

Quality & Equality First

1 ABOUT THIS DOCUMENT

This document sets out the Commissioning Intentions of NHS Warwickshire North Clinical Commissioning Group (WNCCG) that will underpin our contracting requirements for 2014/15, and to take a forward look at the financial years 2015/16 and 2016/17.

It contains the following sections

- **Introduction** – a brief outline of how our commissioning intentions have been developed and how they fit within our development as an organisation
- **NHS Warwickshire North Clinical Commissioning Group (WNCCG)** – an overview of our values, population and the health and wellbeing challenges that we will need to address in Warwickshire North
- **NHS Warwickshire North CCG Integrated Plan** – priorities that we have agreed to work on in 2012/13 and for the years 2013 -2017
- **NHS Warwickshire North CCG Vision for Quality** – outlines our clinical strategy for the next 3 years, and what change we expect across the system
- **Commissioning Principles** – outlines the principles that underpin how financial resources will be deployed to support improvement in the health of the Warwickshire North population. Outlines the basis of high level commissioning intentions that will apply to all providers
- **Commissioning Intentions**
  - Outlines our service vision
  - Provides details on the changes we want to be reflected in all 2014/15 acute contracts but we have provided more detail for George Eliot Hospital NHS Trust (GEH) as our main acute provider
  - Details the changes to community services for Warwickshire North that we would like South Warwickshire CCG to secure in the South Warwickshire Foundation Trust 2014/15 contract on our behalf
  - Outlines the changes to services that we would like the Coventry and Rugby CCG to secure for Mental Health and Learning Disability services in the Coventry and Warwickshire Partnership Trust 2014/15 contract on our behalf
  - There are a number of other contracts where we are part of a larger consortium of CCGs notably Pathology services, West Midland Ambulance Service and the new 111 service. Our specific requirements are also detailed in this section.
- **Contract Timetable** – a high level indication of the deadlines we are going to work to in order to achieve a signed contract by 31 March 2014.

2 INTRODUCTION

Our commissioning intentions for 2014/15 build on the programme of work outlined in the NHS Warwickshire North CCG's Integrated Plan and reflect our clinical strategy as a CCG.

These commissioning intentions are intended to provide our providers and partners with a transparent declaration of the CCG direction of travel and priorities that we will be focusing on in 2014/15.

Whilst the broad strategic direction that underpins the commissioning intentions is reflective of the strategy outlined within the NHS Warwickshire North Integrated Plan 2013, specific commissioning intentions both build on existing Quality Innovation Productivity and Prevention (QIPP) schemes that were established during 2012/13 and reflect new, emergent thinking from clinicians with respect to how services can best be shaped and re-modelled to deliver improved health outcomes whilst securing quality and cost improvements. In line with financial allocations for 14/15, further work will be undertaken to continuously identify and work up in-year QIPP schemes with providers. Whilst the financial challenges are at the forefront of our minds we are also keen that the requirement to reduce cost does not hamper our ability to innovate, improve quality and deliver services differently.

We are expecting more detail to emerge following the publication of the Operating Framework in December 2013. We will need to review these intentions once the requirements become available.

We want to collaborate with our providers, local authorities and other partners to deliver improved services and better health outcomes for the people of Warwickshire North. This means firstly, making the most of the services that we and local authorities commission. A key requirement of providers this year will be for all providers to evidence the right quality of service and the right quality of transfer of patients from one provider to another. We want patients and carers to experience seamless care and the information accompanying patients to be appropriate, timely, accurate and complete to support the best outcomes and experience.

We believe that QIPP schemes need to be worked on together in order to get the best commitment to implement the change from all parties.

The commissioning intention process has been led by the clinical leaders of Warwickshire North CCG and they have been approved by the CCG Executive. They are based on the priorities identified in the Warwickshire Joint Strategic Needs Assessment and Health and Wellbeing Strategy, national and regional priorities, QIPP work streams and views of local General Practices (GP), stakeholders, patients and carers.

CCGs will collaborate with one another through the commissioning cycle process to ensure all parties to any contract are appropriately engaged. The CCG will also collaborate with public health at Warwickshire County Council and NHS England to ensure that everyone is engaged with the collaborative.

3 OUR POPULATION

3.1 Our Values

- Quality and Equality first
- Dignity, respect and compassion in the services we commission
- Working together, improving health and securing sustainable services
- Benefiting the whole community, as wasted resources are wasted opportunities for others.

3.2 Our Population

NHS Warwickshire North CCG has worked with Warwickshire Public Health to identify the Joint Strategic Needs Assessment (JSNA) priorities for Warwickshire North.

Our priorities take into account the health needs identified in Warwickshire's JSNA, which include the needs of:

- Children and Young People (especially Looked After Children)
- Lifestyle factors affecting health (Obesity, Physical activity, Smoking, Alcohol and substance misuse, Sexual health)
- Vulnerable communities (reducing health inequalities, improving care for people with disabilities, and safeguarding)
- Ill health (covering long term conditions, and mental health and wellbeing)
- Old Age (dementia and frail elderly).

The CCG has a statutory duty to reduce health inequalities and by doing so will ensure that the CCG:

- Plans and commissions services in an integrated way across health and social care so that health and social care services better meet everyone's needs within the local community, including people in vulnerable circumstances and those with the worst health outcomes
- Ensuring a focus on vulnerable groups at every stage of the commissioning cycle – from JSNA to contract negotiation rounds – to include people unregistered with general practice, children, people with learning disabilities, severe mental illness, or co-morbidity, and minority ethnic groups, for all service commissioning, and in particular with any potential service reconfiguration
- Making use of provider incentives such as Clinical Quality and Innovation (CQUIN) to target lifestyle factors in health such as breastfeeding promotion, smoking cessation, increasing physical activity etc., and promoting good practice for providers as employers through the contractual framework (such as provision of stop smoking interventions for staff)
- Developing Key Performance Indicators (KPIs) with health inequality-based outcomes relating to specific provider contracts (such as smoking cessation in mental health services)
- Addressing inequalities in primary care by driving up primary care quality and tackling variations in practice performance, and prioritising service provision in deprived areas with poorer health outcomes.

Our Health and Wellbeing Challenges are as follows:

- **The population of WNCCG is growing -** The rate of population growth is below the County rate with the lowest growth in North Warwickshire. Nuneaton and Bedworth's population grew at 5.1% since 2001. Projections show a predicted overall increase of 7.9% (North Warwickshire Borough Council (NWBC)) and 12.6% (Nuneaton and Bedworth Borough Council (NBBC)) by 2033
- **The population of WNCCG is ageing -** In North Warwickshire the over 65 population is expected to grow by 60% by 2030 (48% Warwickshire). In Nuneaton and Bedworth the growth is projected at 43%
- **Health Inequalities Persist -** Life expectancy in the north of Warwickshire is lower than the Warwickshire average, in Nuneaton and Bedworth the rates are significantly lower than the England average. There is considerable variation across the area
- **Educational attainment in the North is significantly below the national Average -** In North Warwickshire the percentage of pupils achieving 5 A*-C grades was 49% and 52% in Nuneaton and Bedworth, with significant variation across the area. Attainment is lower in those who are entitled to Free School Meals
- **Looked After Children and Safeguarding – T**he rate of Looked After Children per 10,000 population is higher in Nuneaton and Bedworth than other areas of Warwickshire at 89 children per 10,000 population. Attainment figures for Looked After Children are significantly lower than achieved by non-Looked After Children. The rate of Child Protection per 10,000 population is highest in Nuneaton and Bedworth compared to the rest of Warwickshire
- **Economy: Unemployment in Nuneaton and Bedworth is the highest in the County -** In July 2012 the claimant count stood at 2,861 a rate of 3.7% of the resident working age population
- **Improved Access to Services -** The rural nature of North Warwickshire means that some people face problems accessing everyday services such as jobs, education, GP surgeries, shops etc. This can be a significant problem for people who do not have their own transport
- **Sexual Health –** Nuneaton and Bedworth has the highest rate of chlamydia (although declining) cases across Warwickshire
- **Mental Well Being** –the positivity measure for Warwickshire North has 8 of the 11 worst measures for the County, although Nuneaton and Bedworth have some of the best measures too
- **Long Term Condition disease prevalence/ incidence/ mortality**
- **Cancer** - Whilst WNCCG has lower cancer incidence, mortality is amongst the highest in Warwickshire particularly in the under 65s. This suggests late detection of cancers. Screening uptake also varies across the area
- **Diabetes** - There appears to be higher identification rates and higher numbers of people on diabetes registers in the North, although there is considerable variation across practices
- **Chronic Obstructive Pulmonary Disease (COPD)** - Evidence suggests that diagnosis in Warwickshire North is higher than the Warwickshire and national rate however; data would suggest more than 30% of patients are still not recorded on the COPD registers. There is significant variation in observed to expected rates across practices. Mortality from respiratory disease is significantly higher in North Warwickshire and Nuneaton and Bedworth in persons aged 65-84 years

- **Coronary Heart Disease (CHD)** - Data suggests a under diagnosis or under recording of CHD in primary care. In addition, mortality from CHD is significantly higher than in England (44.98 rate) for both North Warwickshire and Nuneaton and Bedworth
- **Stroke** - The ratio of expected to actual numbers recorded on the stroke register is lower than the England and Warwickshire average, suggesting an under diagnosis/recording. There are higher mortality rates for all persons in the North of the County compared to England as a whole
- **End of Life Care** - In addition to the disease specific issues mentioned above, there are significantly higher levels of patients across Warwickshire North who are dying in their own homes (22.8%) compared to 20.3% nationally and higher rates in Nuneaton and Bedworth dying in hospital (60.3% compared to 54.5% nationally). For hospital deaths this relates particularly to CHD across the area all causes of death in Nuneaton.

Priorities for upstream interventions and rationale

The 2 partnership priorities for Nuneaton and Bedworth and North Warwickshire that have been agreed in consultation with stakeholders across the area are:

- **Rising levels of obesity -** There is a significantly high prevalence of obesity across Warwickshire North when compared to the national average. 27.3% of adults in North Warwickshire and 29% in Nuneaton classified as obese compared to a Warwickshire average of 25% and a national average of 24.2%. In children, measurements of obesity are also above the Warwickshire rate at 8.5% in North Warwickshire and 9.9% in Nuneaton and Bedworth compared to 7.8% in the County. At Year 6 this rises to 19.5% in North Warwickshire and 17.7% in Nuneaton and Bedworth compare to 16.2% in Warwickshire as a whole
- **Increasing levels of alcohol related harm -** The rate of alcohol related hospital admissions in North Warwickshire and Nuneaton and Bedworth has seen an overall increase in the last 5 years in both males and females. The rate for males in Nuneaton and Bedworth is significantly above the England average.

In addition, smoking remains priority for the NHS in Warwickshire North:

- **Smoking remains the single biggest preventable killer in the UK -** Across Warwickshire North, more than 22% of adults smoke and in Warwickshire 19.6% of women smoked during pregnancy, with numbers increasing.

We are working very closely with public health, North Warwickshire and Nuneaton and Bedworth Borough councils; and Warwickshire County Council to understand the impact of the projected population growth on the Warwickshire North care system.

3.3 Making every contact and interaction count

WNCCG intends to continue to work closely with public health in Warwickshire to ensure that services which influence public health behavioural change are integrated with those services which WNCCG commission. It is essential that all partners work together to make the most of our available resources and continuously reinforce the healthier lifestyles message. It is envisaged that these services will have clear links with health checks and with all services through 'Making Every Contact Count'.

NHS Warwickshire North CCG is committed to listening to our population – our patients, carers and the public. In order to ensure that this is systematically embedded in everything we have developed and implemented a strategy for public engagement to ensure that the decisions we make are in the best interests of patients.

The CCG recognises the importance that everyone has to play in the redesign and delivery of services and therefore we are committed to working jointly with partners to reduce inequalities and develop joint strategic planning and joint commissioning where this leads to enhanced benefits to our population.

3 OUR STRATEGIC DIRECTION

We have made a significant amount of progress in determining our direction of travel over the next three years and have worked to articulate this into a language that is meaningful for our practices, population and partners.

2014/15 will be the second year of delivery of our Integrated Plan, and we will be implementing our Vision for Quality which specifically targets improvement in urgent and emergency care, mental health and dementia, frailty and those at the end of life over the three years 2014/15 to 2016/17.

3.1 NHS Warwickshire North CCG Integrated Plan and Vision for Quality

The NHS Warwickshire North CCG Integrated Plan set out the direction of travel from 2013 to 2017, the Vision for Quality was an action to be completed within the plan, to determine in more detail the quality we expect in four key priority areas. Our commissioning intentions have been based on this. This is particularly important in terms of the financial forecast and the requirement for provider reform.

NHS Warwickshire North CCG has three strategic objectives:

- Making better use of the money we already spend
- Building a sustainable system by investing in prevention, early identification and best care for patients
- Building an excellent CCG that improves outcomes for patients is a great partner to work with and a great place to work

The Integrated Plan outlines our aims for QIPP delivery from 2013 – 2017.

3.2 Vision for Quality

3.2.1 Our approach

The following outlines how we have worked to develop our clinical strategy, our "Vision for Quality":

Patient and Public Feedback

We undertook two patient surveys. One on stroke rehabilitation and one on Urgent and Emergency Care which were both publicised online and sent to GP practices. In addition, for stroke we distributed the surveys via the Stroke Association and local support groups. For urgent and emergency care carried out the survey in public places in Nuneaton and Bedworth and North Warwickshire.

On 29th April the CCG held a patient workshop event at Bedworth Civic Hall for members of the Warwickshire North Patient Group Forum and core members from the voluntary sector such as Healthwatch and Warwickshire Race Equality Partnership.

The event was attended by 30 people and provided a valuable opportunity to listen to people's views and experiences on End of Life; Urgent and Emergency Care; Dementia and Stroke. Each workshop was led by a clinician and a facilitator who gave an overview on each subject before inviting attendees to give their views on each area.

Copies of patient packs from the workshop were sent to all 28 GP practice Patient Participation Groups and additional feedback was gathered and fed in to the clinical strategy.

More than 250 individual comments were collated in response to the questions: what's working well, what's not working well and what's important for the future? Output of this feedback has been fed into the commissioning intentions for the Vision for Quality Services.

Voluntary Sector Feedback

We held a voluntary sector workshop on 19th June 2013 and the day was attended by more than 60 individuals representing 44 organisations. At this event our GPs, staff and partners from the county council also supported round table discussions on the topics of mental health, dementia, stroke/TIA and frailty.

Specialist support groups

CCG engagement staff also attended a number of local community based specialist support groups throughout the spring and summer, to inform them of the work and gather their views and opinions.

Overall, more than 450 individual comments were collated in response to the questions: what's working well, what's not working well and what's important for the future?

GP Feedback

The CCG held 12 fortnightly clinical sessions with representatives from its 28 practices and information packs were sent out prior to the sessions. Each of the 8 service areas were considered at the sessions. Some areas, including urgent and emergency care were discussed on more than one occasion and other sessions were used as consolidation sessions to ensure all representatives were in agreement with the key messages.

At the sessions, where it added value to the debate, we had visiting speakers to give expert input such as Professor Matthew Cooke (Professor of Clinical Systems Design at the University of Warwick), Mr Martin Lee (Medical Director at Arden Area Team), Dr Sharon Binyon (Medical Director at Coventry and Warwickshire Partnership Trust (CWPT)), Dr Rob Holmes (Associate Medical Director at Coventry and Warwickshire Partnership Trust and Dr A Atta (Associate

Medical Director at Coventry and Warwickshire Partnership Trust), Mr Andrew Arnold, (Medical Director, George Eliot Hospital (GEH)), Mr Reddy (Associate Medical Director Surgery) and Dr James Egbuji (Consultant Physician), Dr Meghana Pandit (Medical Director, University Hospital Coventry and Warwickshire (UHCW) and a number of other lead staff from Warwickshire County Council and South Warwickshire Foundation Trust (SWFT) to provide the GPs with information on local services e.g. Commissioner for Dementia from the County Council and Team Leads for Intermediate Care from South Warwickshire Foundation Trust.

Provider Trusts

The CCG Chief Officer and Chair have met with Chief Executives and Medical Directors from our respective providers to brief them on the work. This includes GEH, UHCW, SWFT and Coventry and Warwickshire Partnership Trust.

In addition, lead managers and medical staff from the providers attended an urgent and emergency care workshop in June 2013 to discuss the proposed model for urgent and emergency care. The Medical Directors from the providers have been invited to meet with our GPs on a number of occasions to consider the strategic outputs.

What are the next steps?

Findings from The Vision for Quality and a high level implementation plan was agreed at the Governing Body meeting on 26 September2013.

Further public, patient and voluntary sector engagement is scheduled for October 2013 and findings have already been shared with some of the key providers i.e. George Eliot Hospital, South Warwickshire Foundation Trust, University Hospitals of Coventry and Warwickshire and Coventry and Warwickshire Partnership Trust. A copy of the final draft report has been sent to all member practices; provider organisations; social care and County and local borough councils, West Leicestershire CCG, and shared with the Warwickshire Health and Well Being Board on the 25 September 2013.

Dates to share with and the Warwickshire Health Overview and Scrutiny Committee are being arranged.

3.2.2 Developing the Strategy

The NHS faces some significant challenges:

- More people living longer with more complex conditions
- Increasing evidence that for some conditions better outcomes are achieved by having a smaller number of more specialised services

- Increasing costs whilst funding remains flat or the rising expectations of quality of care. an increasing expectation of patients in terms of choice and living independently for as long as possible
- The support for self-management of long term conditions, rather than the paternalistic medical model.

Here in Warwickshire North, additional to these, we have a population that in neighbourhoods suffers significant inequalities, a difference of 10 years life expectancy for men and 7 years life expectancy for women between the best and worst areas, a population that is served by too few GPs and a small local hospital that is in special measures following the Keogh review which identified urgent priority actions as:

- leadership of quality
- pace of change
- patient locations and moves
- low levels of clinical cover, particularly out of hours
- medical handovers
- sepsis care bundle performance and management
- culture at the trust
- understanding of mortality issues
- incident reporting
- pressure ulcers

Having held discussions with representatives of patients and the public, local GPs and providers, the following principles have been agreed to shape services for patients across the boroughs of Nuneaton and Bedworth, and North Warwickshire:

- Our services should be provided as locally as possible, as long as they are safe, high quality, meet the standards in the NHS Constitution and can achieve the best health and care outcomes for our population. However, this will not affect our patients' rights to choose to receive services elsewhere.
- Our services should be available seven days a week and we need a plan to achieve this.
- It is acceptable for our patients to travel to specialist services if the right standard of care cannot be achieved locally.

The CCG considered, as part of its clinical strategy 8 service areas (4 groupings):

- Urgent and emergency care and Emergency General Surgery; Cardio Vascular Disease (CVD); Stroke, Transient Ischaemic Attack (TIA) and Heart Failure
- Frailty and End of Life
- Dementia
- Mental Health

6 COMMISSIONING PRINCIPLES

The following principles underpin how financial resources will be deployed to support improvement in the health of the Coventry and Warwickshire populations as defined by the Coventry and Warwickshire CCGs in 2012.

All of our providers are expected to:

- Work collaboratively with relevant partner organisation to develop integrated service provision where this is beneficial
- Ensure clear accountability for handover and direction between individuals, teams and organisations
- Ensure that the care delivered is safe, of high quality meeting national and local standards
- Support improvements in health outcomes
- Be clinically effective
- Be cost effective
- Be aiming to move more provision of care into the community or ambulatory care models to replace traditional inpatient care;
- Promote equitable access
- Be responsive to individual and population needs
- Support patient choice – in respect of provider, location and treatment (as appropriate)
- Be affordable within a finite budget
- Contribute to the Warwickshire Health and Wellbeing Strategy and consider their part in addressing the issues and challenges raised within it

Our providers need to assure us that the interventions on patients when care is transferred from the GP to the provider, are adding value. Most specifically, we expect our providers to adhere to clinical pathways and thresholds. Through clinical discussions we expect to expand the number of pathways and gain agreement on an increased number of clinical thresholds. Where guidelines exist nationally (NICE) or locally these must be adhered to.

Commissioners expect their providers to undertake robust capacity planning across services to ensure capacity reflected final contracted activity levels.

In carrying out their commissioning functions, clinical commissioning groups will:

- Work with their local populations to effectively identify local health needs and commission services from the providers best placed to meet the needs of their patients and population
- Commission services from providers who offer a safe and effective service
- Commission services from providers who can offer best value for money
- Commission services from providers who offer timely access to appropriate services
- Work in partnership with providers to identify further areas for QIPP delivery that promote health outcomes whilst reducing costs for both the commissioner and the provider
- Support providers to work collaboratively with each other and with the commissioners (across Health and Social Care) to improve patient experience and assist in seamless Health and Social Care provision, contributing to QIPP savings

- Work towards ensuring there are agreed service specification, contracts and outcome measures for all commissioned services
- Our providers not only have a role in treating illness but preventing it. We therefore expect that providers will deliver services that ensure that 'Every Contact Counts'. Every contact should be seen as an opportunity for a public health intervention.

Our providers should ensure that the ethos of 'No Decision About Me, Without Me' is demonstrable in all services, and we expect that patients and their families/carers be involved in developing care plans and development of services. The CCG will use live feedback from the public, patients and carers to inform our views of the quality of care that is commissioned and provided. Additionally where there is cause for concern, we will undertake more detailed investigation to gain assurance of the quality of service being provided.

7 COMMISSIONING INTENTIONS

7.1 Service vision

We want to systematically tackle the pressures within the health and social care system to deliver better outcomes for our population. To do this we will seek to commission in a way that reshapes the patients experience of care pathways from end to end.

Mortality

Mortality rates are unacceptably high and this must be tackled. The Trust has worked to improve mortality rates, which is evidenced by the last two standardised hospital mortality indicator rates. However, this needs to be further improved upon and sustained longer term. George Eliot Hospital must implement the mortality action plan, the key areas for improvement are:

- Significant improvements in the mortality and crude mortality rates to bring the hospital in line with other peer hospitals
- Focus on leadership – through Medical Director/Deputy Medical Director mortality case note review
- Focus on clinical leadership to address actions from the Keogh review, learning from Mid Staffs/Francis and learning from audits e.g.: record keeping, accuracy of death certificates.
- Evidence of improved and timely medical handover of patients.
- A review of all deaths in the Trust as they occur to identify lessons to learn
- A reduction in the length of stay of patients
- A reduction in the number of patients staying in hospital as part of their palliative care when they could be cared for either at home or in the community
- Significant improvement in management of fluid balance
- Monitoring of the Early warning signs and systems and appropriate action
- Evidence of significant improvement in the actions resulting from the notes audit work identifying poor record keeping
- Reduction in the number of wards patients move through during their stay

NHS Warwickshire North CCG will continue to implement the Arden System Plan.

Urgent and Emergency Care and Emergency General Surgery

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance "blue light" and who need an Accident and Emergency (A&E) or urgent paediatric assessment service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- A&E
  - Providing for patients arriving in 999 ambulances who require emergency treatment, trauma, resuscitation, first presentation of severe illness i.e. those not suitable for other urgent care pathways.
- Specialist medical assessment (frailty)
  - A specialist medical assessment (multidisciplinary team) consisting of emergency physicians and also geriatricians who also have a community portfolio and can provide expert support to GPs and others to allow patients to remain at home where possible, thereby enhancing links out of hospital
- Mental health urgent assessment
  - An urgent mental health assessment to ensure patients with mental health problems are treated and supported for their mental health illness as well as their physical ailment.
- Primary care assessment
  - A 24 hour on site GP/primary medical service to provide in-hours and out of hours assessment and treatment for the local population.
- Social care and community urgent assessment
  - A specialist community health and social care team to provide specialist assessment, access to services to allow patients to stay ambulatory, get quick assessment and return to their home, or to an appropriate other environment to receive care within the community.
- Ambulatory care clinics
  - An expansion of the number of conditions treated in ambulatory and specialist clinics, for advice to GPs and urgent specialist assessment same day/next day, offering more appropriate care and reducing the need for hospital admission.
- Fast diagnostics
  - An expansion of urgent access to diagnostics tests for GPs to appropriately prevent an A&E attendance or emergency admission.
- Accessing an urgent specialist opinion
  - Ability of GPs to access a specialist for an opinion rather than sending the patient into hospital.

Cardiovascular Disease, Stroke and TIA

Stroke/TIA

- Improved management of medical risk factors for stroke/TIA such as high blood pressure and diabetes by peer review of GP practices.
- Ensure we have a robust integrated stroke rehabilitation service with two distinct phases: (1) early supported discharge (ESD) service (for up to six weeks post-discharge from hospital) and (2) community rehabilitation service which takes patients following their discharge from the ESD service.
- Centralise admissions of all patients with an acute presentation of cerebrovascular disease in a specialist centre to maximise their care and then repatriate them to GEH when it is clinically safe to do so. Hyper-acute stroke patients already go direct to UHCW.
- An annual report produced by the stroke and TIA service that reports activity, patient outcomes, patient experience and safety across the patient pathway as well as organisation-specific. This would allow the CCG and patients to be confident that the stroke and TIA services were helping patients achieve good outcomes.

CVD and Heart Failure

- Work with partner agencies to collaborate on optimising the impact of all our actions to reduce cardiovascular risks.
- Agree and implement a heart failure pathway between primary and secondary care with clear stages and responsibilities, including appropriate diagnostic waits.
- Access to urgent specialist opinion for GPs to prevent patients being admitted unnecessarily
- Production of an annual report by the cardiologists at GEH describing audits and key performance indicators. In addition, describing improvements to meet the challenges following the West Midlands Quality Review Service (WMQRS) review.
- Maintain the provision of NHS Health checks in all GP practices in Warwickshire North, ensuring vulnerable groups are targeted. Agree a plan to address any variation at practice level.
- Working with partners to create greater access and uptake of lifestyle management services where this is necessary.
- Procure a cardiac rehabilitation service which builds on utilising local lifestyle management services and exercise on referral schemes and offers more specialist services where it is appropriate.
- Standardise referral pathways and referral forms to improve the quality of referral through the DXS system for CVD.
- Improve QoF performance against relevant indicators, especially blood pressure.

Frailty

- Development of a Specialist Medical Assessment Unit (Frailty) at GEH site with geriatric input into the community to prevent admissions and better treat patients outside of hospital.
- Access to urgent specialist opinion for GPs to prevent patients being admitted unnecessarily
- Closely aligned mental health, social care and community teams working with GEH to ensure a seamless admission into hospital and discharge from inpatient stay. Some admissions and length of stays will be avoidable with more appropriate non-hospital services and workable pathways.
- Ensuring that all opportunities for joint commissioning of integrated services are exploited.
- Exploring ways to appropriately address the rising admissions from residential homes where care is best provided in the home.
- Annual plan from GEH outlining achievement against standards outlined in the Silver Book 2012 (The Geriatrics Society), as well as participating fully in all relevant national audits (e.g. Stroke, hip fracture, dementia, falls and bone health, continence).
- Risk stratification of patients in GP surgeries to proactively manage their conditions outside of hospital.
- Work with Warwickshire County Council to implement the Carers Strategy 2012-2015.

End of Life

- Primary, community, secondary care, voluntary organisations and hospices working in a more integrated way to ensure the number of patients who die in their place of choice increases.
- Enhance community end of life care to enable people to be cared for in their usual place of residence.
- Ensure our acute hospitals have a systematic approach to supporting the identification of people approaching the end of life and coordinating their care across organisational and professional boundaries.
- Increased number of patients on GP palliative care registers who are enabled to die at home. This will be facilitated by practices using a risk stratification tool to identify them.
- Implement an assessment and advance care planning for people identified in the last year of life, particularly those with dementia where capacity may become an issue; and with the patient's consent enter details on Electronic Palliative Care Coordination system.
- Work with Warwickshire County Council to implement the Carers Strategy 2012-2015.
- Increase the availability of carer respite to support those caring for the person who is approaching the end of life.
- Build end of life care competence and capacity in the primary care workforce.
- Promote the use of national best practice tools in end of life care, including prognostication tools to support primary care teams in identifying when patient needs are changing and a different approach to their care is required.
- An increased focus on identifying people at the end of their lives in nursing homes and with advanced dementia and proactively making advanced plans for their care.
- Improved training and literature on end of life discussions and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

Mental Health

- Continue to review the care of those patients placed out of the area and where appropriate care for near to Warwickshire for those with a mental health illness, personality disorder or degree of autism
- Review the role of the Crisis Resolution team and their impact on preventing admissions.
- Further understanding and use of Care Clusters, which is how mental health care will be commissioned from 2014/2015.
- Improve communication between secondary and primary care using CQUIN; the CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of providers' income to the achievement of local quality improvement goals.
- Improvement of the Eating Disorder Service (via NHS England).
- Integration of all Single Point of Entries into one referral point to make access to all services simpler (as planned by CWPT).
- Further development of the psychiatric liaison team and linking directly with the Single Point of Contact at the front end of GEH A&E.
- Improved waiting times for IAPT.
- Maintenance of the Child and Adolescent Mental Health Service (CAMHS) waiting times.
- Improved coordination and management of patients with a dual diagnosis of a mental illness and drug or alcohol dependence between Coventry and Warwickshire Partnership Trust and the Recovery Partnership.
- Ability to access a specialist opinion from a consultant psychiatrist for urgent advice through the single referral route.

Dementia

- Ensuring that opportunities for integrated care are secured by working with Warwickshire County Council and others through joint commissioning.
- Requirement for brain imaging (Computerised Tomography (CT) scan) to be undertaken prior to patients being seen in the memory clinic, so that there is one appointment when all results are available to the expert.
- Improve diagnosis rates of dementia through primary care (GP direct enhanced service) and secondary care CQUIN.
- Work with Warwickshire County Council to implement the Carers Strategy 2012-2015.
- An agreed and documented patient pathway across health, social care and the voluntary sector in line with NICE guidance. Specifically, in health, this would pick up:
    - Improvement in the post diagnosis support for patients and families.
    - Improved information for patients and carers at time of diagnosis.
    - Increase in support for patients through Admiral nursing (Admiral Nurses are mental health nurses specialising in dementia) or Dementia Advisor

Increase in community teams and assessment to increase the amount of care received closer to home.

- A Crisis Resolution Home Team to increase the responsiveness of services into people's homes.

- Further development of The Arden Mental Health Acute Team (AMHAT) which will be linked with the Urgent Care Centre and also provide support for patients with mental health problems and dementia to UHCW

Elective Care

NHS Warwickshire North CCG intends to commission services and pathways which improve patient experience, remove unwarranted attendances at hospital and reduce resource burden to both commissioners and providers. The CCG intends to work with providers to commission efficient pathways of care to deliver on the 18 week promise, make services as person centred and streamlined as possible - removing any inefficiencies and ensuring effective patient centred handovers between individuals, teams and organisations.

The CCG wishes to see clinical networks in place for stroke, subspecialty medicine, emergency general surgery and paediatrics, so that services can safely be delivered locally with robust clinical governance, clinical audit, workforce rotas, learning and development can be achieved to deliver the best outcomes irrespective of location. This will also ensure that the right elective and emergency conditions are seen by the right person, with the right competency, experience and skills in the correct clinical environment.

Rehabilitation and connecting with other services

Rehabilitation should get patients back to levels of quality of life as close as to previous to illness. WNCCG intends to ensure that patients/clients have a positive outcome in relation to their care as outlined in the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- The CCG will ensure that all providers adopt the NHS Outcomes Framework along with corresponding outcomes indicators.

WNCCG intends to Improve the quality of care that people receive in residential and nursing homes. Part of this will be having specialist services that can work with homes to care for patients proactively as to avoid instability and management of infection but also to respond rapidly to assess and advise patients with deteriorating health. The CCG also intends to ensure residential staff have sufficient training and support to enable residents to die in the home rather than in hospital.

NHS Warwickshire North CCG wishes to work jointly with providers to develop a range of rehabilitation services to meet the needs of the population. Rehabilitation is a key component of all pathways for long term conditions. It has an established role in pathways for people with cardiac disease and heart failure, chronic lung disease and chronic neurological conditions. Rehabilitation services can support safe, supported and timely discharge from hospital - especially

for people with complex needs - reducing hospital length of stay. Other benefits of rehabilitation services include reduced dependency on health and social care support and associated costs and it also delivers significant cost savings through alternative pathways of care and reduced longer term support costs.

In the case of specialised services, commissioned by NHS England, WNCCG wishes to work with these commissioners to ensure that our population receives seamless care.

Early identification, prevention and best management

An essential component of care for patients with long term conditions is the focus on early identification of long term conditions, self-management where appropriate and comprehensive care planning. WNCCG would like to work together with partners to review the long term conditions pathways across the area to ensure that the provision of coordinated, integrated care across hospital, community, primary care and social services as identified in the WMQRS 2012. The aim being to avoid unnecessary admissions, achieve reduced lengths of stay (LOS) whilst maintaining or improving the quality of care that patients receive. CVD is a particular priority identified in the Vision for Quality.

Though the ambulatory care team, the CCG would like to see the development of phone advice and hot clinics in order to prevent admissions and treat those patients suffering with exacerbations of chronic illnesses, for instance; COPD, CVD etc. as stated earlier.

The CCG will work with other commissioners to review the learning disability services and services for those with autism in line with the Joint Strategic Needs Assessments carried out in these areas.

Learning Disability Services

- Adjustments are in place to accommodate the health needs of people with learning disabilities accessing acute care. Building on the evidence from the national review and direction about the particular health risks and issues impacting on people's experience and outcomes of health services.
- The CCG has reviewed with local authority colleagues all patients placed out of the area who are placed in a hospital setting (reference Winterbourne) to ensure they are receiving the right care in the right place and where appropriate, provide care closer to Warwickshire. This coming year we will widen our review to additionally include patients with both a learning disability and an additional mental health disorder.
- The CCG would like to ensure the review of care packages and decision making for those with Learning Disabilities admitted for treatment and assessment to ensure a more timely discharge and prevent readmission.

Children and maternity

The CCG believes that Children and Young People need holistic care that meets their needs and will work jointly with partners and providers to ensure that children, young people, their advocates and carers are involved in their care planning to ensure that care is centred around the child/young person.

The CCG will work with partners across health, social care and education to develop and implement a Children and Young People's Plan.

We will commission services that ensure that when children have complex care needs that their care is provided in a seamless way to ensure that children are able to live as full and independent life as possible.

WNCCG will develop and maintain links to the West Midland's Maternity and Children's Strategic Clinical Network in order share evidence and best practice for paediatric and maternity services. We will be active members of the Arden Maternity Network that was established September 2013; the remit of the Network is to reduce risk and variation across the local maternity services delivering positive outcomes for mothers and babies.

For Paediatrics the CCG wishes to explore how the additional doctors and nurses can help us to better support the most complex children (looked after children; high numbers of troubled families; and child abuse).

The CCG will work with other agencies to ensure joint working with education, social care and other strategic partners. When a child is absent from school due to illness or health reasons that partners work together to ensure that the child and family are supported.

The CCG will work with partners to see improved integrated sharing of information between police, health and social care, working with the Warwickshire Safeguarding Children's Board to understand the issues in Warwickshire North and the reasons we have so many children on child protection plans so that we can work in partnership on earlier intervention.

The CCG is committed to ensuring that the transition from Children's to Adult services is integrated across Providers to support young people in the Transition to adult services.

The CCG wishes to see the implementation of the recommendations from the West Midlands Quality Review (November 2012) and that all the quality standards to achieve the paediatric diabetes best practice tariff are met. The priority areas include:

- Appropriate staffing levels to support 140 children and young people a year
- Number of children managed on insulin pumps increase from 9% to 15% in line with NICE guidance
- Point of care HBA1c testing (or robust alternative) available in paediatric diabetes clinics, resulting in fewer venous samples. Immediate results are particularly beneficial for poorly compliant teenagers.
- Programme of regular audit and data collection
- Transition to adult services

In terms of maternity, the CCG would like to ensure the following:

- The midwife to birth ratio is maintained at 1:32.
- A reduction in C-Section rates and a greater improvement in inter uterine growth restriction (IUGR) screening detection to reduce the number of still birth in line with the national average.
- Improved recording of data and the measurement of care.
- Implementation of the pathway review on the care of mothers who are identified as "high risk" to ensure that mothers who are high risk are seen at specialist centres
- Working with public health colleagues to achieve a reduction of smoking in pregnancy

Lifestyle Interventions

Smoking (maternity and mental health)

Smoking has a significant impact on the health of people with mental health problems, with higher levels of smoking responsible for a large proportion of the excess mortality of people with mental illness.

Smoking can cause complications in pregnancy, including increased risk of miscarriage, premature birth and low birth weight. Passive smoking can cause wheeze and asthma, middle ear infection and sudden infant death among children whose mothers smoke.

- Trusts should provide intensive stop smoking support for people using mental health services
- Trusts should provide intensive stop smoking support for people using maternity services
- Trusts should monitor and audit the level of patient referrals and uptake of stop smoking interventions to include both the number of referrals and the number of referrals that result in people stopping smoking
- Performance management of stop smoking services in trusts should include: smoking status at discharge from care, smoking status of mothers at time of delivery, and long-term stop smoking (quit) rates

In particular the following specific key performance indicators will be commissioned:

- 100% of pregnant women offered CO monitoring at booking; 95% are monitored
- 100% of pregnant women have smoking status recorded at booking
- 100% smokers in pregnancy are offered specialist smoking cessation support; 75% are seen by the service
- 100% of women have smoking status recorded at time of delivery

Making Every Contact Count (MECC)

Making every contact count ensures that all opportunities, through face to face contact, to support people to make informed lifestyle changes are taken. It also ensures that there is consistency in messages regarding healthy lifestyle across all providers of services.

- Ensure MECC is embedded in all Service Specifications
- Ensure that there is a trained 'MECC Champion' in each clinical area or nursing team
- Each trust to have a clear action plan to achieve rolling out of MECC to all front-line clinical staff by March 2018

In particular the following specific key performance indicators will be commissioned:

- All provider trusts will have a named MECC champion in each clinical area/ nursing team
- Each provider has a clear action plan to roll out MECC
- 100% of frontline staff are MECC trained by March 2018

Immunisation (Influenza and Measles Mumps and Rubella (MMR))

- Trusts will pro-actively and robustly offer flu vaccinations to front line clinical staff, as per DH guidance, with the aim to ensure a minimum of 90% uptake
- Trusts will undertake flu vaccinations with long stay in-patients in clinical risk groups during the flu vaccination campaign. They will also ensure that the GP is informed of the vaccination by fax or email within 7 working days of the immunisation being given
- Trusts will ensure that staff working in outpatient clinics will robustly and proactively encourage patients in eligible clinical risk groups (as per Department of Health (DH) guidance) to attend their own registered GP practice for flu vaccination
- Trusts will ensure that staff working in community and hospital antenatal clinics will robustly and proactively encourage all pregnant women to attend their own registered GP practice for flu vaccination
- Trusts will proactively and robustly ensure that all frontline and clinical staff have evidence of immunity to measles either by antibody titre levels or evidence of two doses of MMR vaccine

In particular the following specific key performance indicators will be commissioned:

- Achievement of 10% increase year on year in frontline staff flu immunisations

Breast feeding

Increase in initiation of breast feeding has been a requirement for a number of years. Warwickshire has prioritised the achievement of the UNICEF Baby friendly initiative (BFI) across all maternity and community providers.

- BFI stage 3 achieved by December 2015 by all maternity providers
- 75% breast feeding initiation achieved by March 2014

Maternal obesity

Maternal obesity is a key risk factor in terms of pregnancy outcomes. All maternity providers are to develop and implement a maternal obesity pathway by March 2014.

Community-based Services

All services provided in the community should continue to be provided from those locations to ensure that the local area receives services local to them. Therefore all contracts will require a schedule of where each service is provided from.

7.2 CQUIN

It is anticipated that as in 2013-14, the majority of CQUIN schemes will support the implementation of agreed patient safety and QIPP initiatives.

7.3 Any Qualified Provider

There is an expectation that Commissioners will continue to increase patient choice in local services via the Any Qualified Provider (AQP) route during 2014-15. Providers will be expected to work with Commissioners to identify services where AQP could be beneficial to patients and engage with the Commissioner s during any consultation phases prior to the qualification process.

WNCCG will endeavour to share information with Providers who maybe affected by AQP in a timely manner as possible. Appropriate notice for a variation in service will be given by the commissioners for any services moving to AQP.

7.5 Specific Commissioning Intentions: George Eliot Hospital NHS Trust

Mortality

Mortality rates are unacceptably high and improvements in the quality and care and treatment must be tackled. The Trust has worked to improve mortality rates, which is evidenced by the last two standardised hospital mortality indicator rates. However this needs to be further improved upon and sustained longer term. George Eliot Hospital must implement the mortality action plan, the key areas for improvement are:

- Significant improvements in the mortality and crude mortality rates to bring the hospital in line with other peer hospitals
- Focus on leadership – through Medical Director/Deputy Medical Director mortality case note review
- Focus on clinical leadership to address actions from the Keogh review, learning from Mid Staffs/Francis and learning from audits e.g. record keeping, accuracy of death certificates.
- Evidence of improved and timely medical handover of patients.
- A review of all deaths in the Trust as they occur to identify lessons to learn
- A reduction in the length of stay of patients
- A reduction in the number of patients staying in hospital as part of their palliative care when they could be cared for either at home or in the community
- Significant improvement in management of fluid balance
- Monitoring of the Early warning signs and systems and appropriate action
- Evidence of significant improvement in the actions resulting from the notes audit work identifying poor record keeping
- Reduction in the number of wards patients move through during their stay

Patient experience and quality of care

- **No decision about me, without me** - Providers are expected to embrace the national policy and to ensure that all their clinical processes support informed patient choice and decision making.
- **Making every contact count** - Key public health messages to be conveyed at each contact with patients
- **Avoidable harm** - To avoid the number of pressure ulcers, Health Care Acquired Infections, falls and medication errors
- **CQUINs from 2013-14** - providers are expected to ensure that all the CQUIN's from 2013-14 are mainstreamed into core delivery and that CQUINS form previous years continue to be part of the core offer
    - Friends and Family Test
    - NHS Safety Thermometer – Improvement
    - Dementia
    - VTE (Venous Thromboembolism)
    - Mortality
    - Response to Francis
    - Outpatient and Elective Care
    - Specialist Palliative Care
- **Patient experience -** Providers are expected to develop an agreed work plan to improving patient experience through learning and listening to patients and their carers
- **NHS Constitution -** Providers are expected to provide services in line with the NHS Constitution
- **Outcomes framework –** WNCCG intends on ensuring that patients/clients have a positive outcome in relation to their care as outlined in the NHS Outcomes Framework:
- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm
- The CCG will ensure that all providers adopt the NHS Outcomes Framework along with corresponding outcomes indicators.

Urgent and Emergency Care and Emergency General Surgery

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance "blue light" and who need an A&E or the paediatric assessment service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- A&E
  - Providing for patients arriving in 999 ambulances who require emergency treatment, trauma, resuscitation, first presentation of severe illness i.e. those not suitable for other urgent care pathways.
- Specialist medical assessment (frailty)
  - A specialist medical assessment (multidisciplinary team) consisting of emergency physicians and also geriatricians who also have a community portfolio and can provide expert support to GPs and others to allow patients to remain at home where possible, thereby enhancing links out of hospital
- Ambulatory care clinics
  - An expansion of the number of conditions treated in ambulatory and specialist clinics, for advice to GPs and urgent specialist assessment same day/next day, offering more appropriate care and reducing the need for hospital admission.
- Fast diagnostics
  - An expansion of urgent access to diagnostics tests for GPs to appropriately prevent an A&E attendance or emergency admission.
- Accessing an urgent specialist opinion
  - Ability of GPs to access a specialist for an opinion rather than sending the patient into hospital.

Cardiovascular Disease, Stroke and TIA

Stroke/TIA

- Centralise admissions of all patients with an acute presentation of cerebrovascular disease in a specialist centre to maximise their care and then repatriate them to GEH when it is clinically safe to do so.
- An annual report produced by the stroke and TIA service that reports activity, patient outcomes, patient experience and safety across the patient pathway as well as organisation-specific. This would allow the CCG and patients to be confident that the stroke and TIA services were helping patients achieve good outcomes

CVD and Heart Failure

- Agree and implement a heart failure pathway between primary and secondary care.
- The ability for GPs to access immediate advice from a senior specialist. This is also a part of the proposed Urgent and Emergency Model of Care.

- Production of an annual report by the Cardiologists at GEH describing audits and key performance indicators. In addition, describing developments to meet the challenges following the WMQRS review.

Frailty

- Development of a Specialist Medical Assessment Unit (Frailty) at GEH site with geriatric input into the community to prevent admissions and better treat patients outside of hospital. This is part of the Model for Urgent and Emergency Care.
- The ability for GPs to access immediate advice from a senior specialist. This is also a part of the proposed Urgent and Emergency Model of Care.
- Closely aligned health and social care community teams working with GEH to ensure a seamless admission into hospital and discharge from in patient stay. Some admissions and LOS will be avoidable with more appropriate non-hospital services and workable pathways.
- Annual plan from GEH outlining achievement against standards outlined in the Silver Book (The Geriatrics Society) as well as participating fully in all relevant national audits (e.g. Stroke, hip fracture, dementia, falls and bone health, continence).

End of Life

- Primary, community, secondary care, voluntary organisations and hospices working in a more integrated way to ensure the number of patients who die in place of choice increases.
- Ensure our acute hospitals have a systematic approach to supporting the identification of people approaching the end of life and coordinating their care across organisational and professional boundaries

Mental Health

- Further development of the psychiatric liaison team and linked directly with the Single Point of Contact at the front end of GEH A&E

Dementia

- Acute hospitals have increased staff training in managing dementia, to increase the identification and referral of patients for Memory Assessment (CQUIN incentivised in 12/13) however GPs report inconsistency of information getting back to them about patients assessment and referral to a memory clinic. Providers to ensure that the result of any dementia screening and any action taken by the Trust is included in the discharge letter and is communicated to any relevant clinicians and carers.

Care Homes

- Developing support services that can work with homes (involving GP and specialist input) to care for patients proactively as to avoid instability but also to respond rapidly to assess and advise patients with deteriorating health
- Ensure residential home staff have sufficient training and support to enable residents to avoid unnecessary hospital admission and where necessary to die in the home rather than in hospital
- Standardisation of care across nursing homes to improve level of care across WNCCG and reduce unnecessary attendances to hospital

Cancer

- We wish to see providers working in a networked model across CCGs and Specialised Commissioning to provide cancer services. This will include the commissioning of site specific cancer groups and a review of current multi-disciplinary teams for cancer.
- Providers are expected to raise local awareness and early diagnosis for agreed cancer initiatives
- Providers need to adjust assumptions for the change in Chemotherapy tariff; impact of chemotherapy drugs and specialised commissioning; impact of sub-cut chemotherapy and provision of care
- Providers should work with other agencies to signpost to Citizens Advice Bureau/financial support
- Providers should implement the findings for improvement from cancer peer reviews in a timely way
- Providers need to adjust capacity assumptions for endoscopic capacity/introduction of flexi-sig within the bowel screening programme
- Providers need to increase the percentage of Image Guided Radio Therapy (IGRT)/ Specialised commissioning
- Providers may need to develop plans to test Human Papilloma Virus (HPV) for head and neck cancer
- Providers need to adjust assumptions for the impact of reduced availability of Bacillus Calmette-Guerin **(**BCG) to treat bladder cancer, leading to higher numbers of surgery and impact on critical care
- Providers to ensure positron emission tomography (PET) scanning to assess response to cancer treatment is in line with evidence based practice
- GEH needs to increase magnetic resonance imaging (MRI) capacity
- Providers need to conform with the Cancer Outcomes and Services Dataset
- Providers need to ensure complete cancer staging information is sent to West Midlands Cancer Intelligence Unit (WMCIU) for at least 70% of all cancers
- The CCG expect no patient to wait over 100 days for cancer treatment.

Mental Health, Learning Disabilities, Substance Misuse and Dementia

- **Learning Disabilities** - Reasonable adjustments are in place to accommodate the health needs of people with learning disabilities accessing acute care. Building on the evidence from national review and direction about the particular health risks and issues impacting on people's experience and outcomes of health services.

Childrens' and Maternity Services

- **Transition from Children's to Adult services** - Commissioners wish to explore means of enhancing integrated working across Providers to support young people in the transition to adult services
- **Paediatrics** – Continue to commission paediatric inpatient services at UHCW, with all other services remaining at GEH alongside the 16-hour short stay paediatric assessment unit (SSPAU).
- **Paediatric Diabetes –** The CCG wishes to see the full implementation of the recommendations from the West Midlands Quality Review (November 2012) and that all the quality standards to achieve the paediatric diabetes best practice tariff are met. The priority areas include:
    - Appropriate staffing levels to support 140 children and young people
    - Number of children managed on insulin pumps increase from 9% to 15% in line with NICE guidance
    - Point of care HBA1c (Glycated Haemoglobin) testing (or robust alternative) available in paediatric diabetes clinics, resulting in fewer venous samples. Immediate results are particularly beneficial for poorly compliant teenagers.
    - Programme of regular audit and data collection
    - Transition to adult services
- **Maternity** – see a reduction in C-Section rates and an improvement IUGR (inter Uterine growth restriction) screening detection to reduce the number of still birth babies in line with the national average

Emergency care

- **Urgent care redesign** - The CCG intends to work with stakeholders to commission a redesigned urgent care system. The aim being to ensure that patient's needs are being met in an emergency through integrated service provision for urgent primary care, minor illnesses/injuries and 999 emergencies.

Outpatients and Elective Care

- **Outpatient pathway redesign** - Commissioners wish to streamline outpatient pathways to improve patient experience, remove unwarranted attendances at hospital and reduce resource burden to both commissioners and providers
- **Consultant to Consultant referrals** – in line with policy, commissioners wish to minimise consultant to consultant referrals and will not pay for consultant to consultant referrals outside of the policy
- **Physiotherapy** - Commissioners will explore means of increasing the cost effectiveness and access of physiotherapy services improving integration across the primary and secondary care interface and by agreeing criteria to ensure that patients both access the service appropriately and are discharged in a timely manner when treatment is not having the desired clinical impact
- **Access** – all services commissioned should be in line with national targets for patient access in line with the NHS Constitution
- **Pathways** – commissioners wish to agree a programme of pathway reviews to ensure that they are efficient, person centred and effective.

Capacity and demand plan

- **Bed base** – commissioners wish to agree a plan with the Trust that will adjust its bed base to reflect the impact of service change and reductions in length of stay, for example; the shift from inpatient management to day case and Outpatient Procedures; the impact of schemes to prevent inappropriate admission and to expedite discharge from hospital.

Prescribing and Secondary Care Drugs

- **High Cost Secondary Care Drugs –** No payment for Payment by Results (PBR) excluded drugs unless Provider can demonstrate compliance with NICE guidance or agreed local prescribing protocol
- **Home care medicines** - Providers are expected to continue to implement the 3 year strategy for home care medicines and services and their supply, as per the DH Homecare review, and to be implementing year 2 of this from 1 April 2014.
- **Blueteq** – Agree a rollout plan to implement Blueteq proformas across the Trust to ensure high cost drugs are being used in line with NICE/local criteria.
- **Preferred products** – to review the use of less expensive products, (e.g. biosimilars, Certolizumab) with clinical engagement to generate cost efficiencies for both provider and commissioner.
- **Repatriation** – to explore the opportunities for repatriation of drugs which can be purchased cheaper by the hospital than by community services or homecare companies.

Tuberculosis (TB) Service

WNCCG along with the other Coventry and Warwickshire CCG's intends to review the current TB service to ensure that the best outcomes are achieved for patients within the current resource

Patient Transport Services

Commissioners intend to retender the service; this will impact on the 2014/15 contract

Community-based Services

All services provided in the community should continue to be provided from those locations to ensure that the local area receives services local to them. Therefore all contracts will require a schedule of where each service is provided from.

General

- Commissioners expect that all providers will comply with all guidance issued by the Department of Health in relation to new or revised targets, counting and charging, changes to PBR and other national priorities
- Commissioners expect that all providers will have plans in place and be able to demonstrate compliance with/progress towards (as applicable) the national innovation targets as set out in Innovation, Health and Wealth (November 2011)
- The Trust is expected to achieve national requirements in respect of the national Maternity Pathway tariff

- Non-PBR prices – the national tariff inflator/deflator figure per the 2014/15 Operating Framework will be applied to all non-PBR prices
- Local prices will be agreed and offer flexibility to support innovation in care pathway redesign

Terms and Conditions

- All providers will be expected to provide CCG specific contract monitoring reports
- Commissioners will not pay for any self-referrals to outpatients unless as part of an agreed pathway
- Commissioners will not pay for any cancelled operation on the day of the operation for non-clinical reasons
- No payment for consultant to consultant referrals outside policy
- No payment for LPP/Aesthetic procedures outside of policy
- No payment for PBR excluded drugs unless Provider can demonstrate compliance with NICE guidance or agreed local prescribing protocol
- Where an incomplete data set is submitted, 5% of the funding will be withheld until the full data set is submitted on which Commissioners will then raise queries, as appropriate
- Target response times to be agreed for Advice and Guidance requests made via Choose and Book
- All providers are expected to share via the Clinical Quality Review (CQR) meetings, the quality impact assessments that they undertake for their internal cost improvement programmes
- All providers are expected to share via the CQR meetings, any reports they prepare for their own Boards in relation to Energising for Excellence
- Electronic transfer of letters needs to be universal
- Discharge letters to include clear description of future management plan and discharge care arrangements
- Any proposed changes to PBR prices must be notified to the CCG by 1 January 2014. Changes to non-PBR prices will only be agreed if it is shown that existing prices are clearly out of line with national benchmarked figures
- Provider to notify commissioners of proposed pricing structure changes associated with those areas that will attract a local tariff e.g. Excluded Devices. Commissioners intend to review non-PBR pricing structure to ensure this is in line with West Midlands providers
- Provider to notify commissioners of its intentions to charge for new activity or make changes to existing pathways that will impact on costs e.g. QIPP
- All locations of services will be listed in the contract
- The CCG wishes to explore new contracting mechanisms including prime provider contracts

7.6 Specific Commissioning Intentions: South Warwickshire Foundation Trust Community Health Services

We, along with other CCGs in the area, would like to work with South Warwickshire CCG to secure the following community commissioning intentions for 2014/15 in the SWFT contract on our behalf:

- A comprehensive review and re-commissioning of community services
- Integrated health and social care teams with shared records where in the best interest of the patients
- Better regular information on the quality and volume of service delivered evidencing adequacy of resource for population need
- Better integration and linked services between GP and primary care teams, and community services and teams to improve continuity of care.
- Ensure care is based on need
- Prevent inappropriate secondary care admission
- Facilitate early secondary care discharge
- Prevent inappropriate admissions to nursing and residential care so that patients do not become unnecessarily institutionalised and are given every opportunity to regain their independence and return to their original place of residence
- Reduce impairments attributable to long term conditions
- Rehabilitate to the optimum so that patients return to the level of independence they had before becoming unwell
- Promote social inclusion where appropriate
- Allow the development of patient capability in self directing their care and self-managing their conditions
- Support integrated health and social care for children and young people so that the transition between care provided for a child as he or she grows up is managed
- Allow patients to end their lives in the place of their choice
- Adopt the principle of “referrer decides” so that patients who are referred to community health services are accepted, trusting the judgement of the referring professional

Specifically for NHS Warwickshire North CCG we would like to ensure the following is commissioned:

Urgent and Emergency Care

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance “blue light” and who need an A&E service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- Specialist medical assessment (frailty)

  - A specialist medical assessment (multidisciplinary team) consisting of emergency physicians and also geriatricians who also have a community portfolio and can provide expert support to GPs and others to allow patients to remain at home where possible, thereby enhancing links out of hospital

- Social care and community urgent assessment
  - A specialist community health and social care team to provide specialist assessment, access to services to allow patients to stay ambulatory, get quick assessment and return to their home, or to an appropriate other environment to receive care within the community.

Frailty

- Closely aligned health and social care community teams working with GEH to ensure a seamless admission into hospital and discharge from in patient stay. Some admissions and LOS will be avoidable with more appropriate non-hospital services and workable pathways.

End of Life

- Primary, community, secondary care, voluntary organisations and hospices working in a more integrated way to ensure the number of patients who die in place of choice increases.
- Enhance community end of life care to enable people to be cared for in their usual place of residence
- Ensure our acute hospitals have a systematic approach to supporting the identification of people approaching the end of life and coordinating their care across organisational and professional boundaries

Care Homes

WNCCG is cognisant of issues with regard to the capability and resilience of the care home sector. The CCG would wish to work with the community teams to ensure that community services as they develop continue to enhance the wider system capability, preventing crisis intervention and working to reduce unnecessary admissions to hospital.

Tissue Viability

WNCCG is aware of the pilot work on reshaping leg ulcer management to include specialist tissue viability input to clinics and the successful impact that this had on healing rates and therefore outcomes for patients. The CCG supports proposals to roll out this model within the current resource and the savings both in prescribing and District Nursing time that this will deliver.

Community services

Community services should be linked closely with GP Practices to co-ordinate care, risk stratify and target support for patients to allow them to stay at home and prevent unnecessary admissions to other services.

7.7 Specific Commissioning Intentions – CWPT

Urgent and Emergency Care and Emergency General Surgery

Single Site Urgent Care Centre co- located with A&E and based at the GEH site

No change is proposed for patients who are transferred by ambulance "blue light" and who need an A&E service. All other patients who arrive at the Urgent Care Centre (UCC) will be streamed (through the single point of access) to the best team of professionals to meet their needs.

- Mental health urgent assessment
    - An urgent mental health assessment to ensure patients with mental health problems are treated and supported for their mental health illness as well as their physical ailment.

Mental Health

- Further understanding and use of Care Clusters which is how mental health care will be commissioned from 2014/2015.
- Maximise use of communication CQUIN to improve communication between secondary and primary care
- Integration of all Single Point of Entries into one referral point to make access to all services simpler (as planned by CWPT). Audit trail to be available to referrers
- Further development of the psychiatric liaison team and linked directly with the Single Point of Contact at the front end of GEH A&E
- Improved waiting times for IAPT
- Maintenance of the CAMHS waiting times
- Improved coordination and management of patients with a dual diagnosis of a mental illness and drug or alcohol dependence between Coventry and Warwickshire Partnership Trust and the Recovery Partnership
- Ability to access a specialist opinion from a consultant psychiatrist for urgent advice through the single referral route and one telephone number
- Improvement of the Eating Disorder Service

Dementia

- An agreed and documented patient pathway across health, social care and the voluntary sector in line with NICE guidance. Specifically, in health, this would pick up:
    - Improvement in the post diagnosis support for patients and families
    - Improved information for patients and carers at time of diagnosis
    - Increase in support for patients through Admiral nursing or Dementia Advisors
- Requirement for brain imaging (CT scan) to be undertaken prior to patient being seen in the memory clinic. This already takes place but not prior to referral in a one stop shop model.
- Coventry and Warwickshire Partnership Trust are undergoing the following developments which are supported by the CCG in addressing issues which have been raised in the review:
    - Post diagnosis support is being developed

  - Investment is being made in community teams and assessment to increase the amount of care received closer to home. These should link into general community teams to ensure that all needs are met in one coordinated plan.
  - A Crisis Resolution Home Team is also being developed to increase the responsiveness of services into people's homes.
  - The Arden Mental Health Acute Team (AMHAT) has been established to increase links between acute hospital care and mental health services, speeding up the process for patients accessing appropriate support
  - Acute hospitals have increased staff training in managing dementia, to increase the identification and referral of patients for Memory Assessment (CQUIN incentivised in 12/13)
- The CCG will clarify the policy for dementia specific medication
- Improve diagnosis rates of dementia through primary care (GP direct enhanced service) and secondary care (CQUIN) which is monitored as part of the quality and contracting process.
- An increase in the options available for carer respite

7.8 Pathology Contract

The Commissioners are keen to work with the Pathology Network in order to achieve the following for the Contract 2014/15:

- To continue the implementation of Order Comms to a successful completion.
- To work with the CCG to continue the review of Phlebotomy services to improve both Domiciliary and clinical and community based locations phlebotomy services to the advantage of patients and to improve equity of access for patients.
- To review and continue ongoing CQUIN projects where necessary
- To work towards "Transforming Pathology Services" goals to ensure the effective continued Pathology Services for patients in the Coventry and Warwick areas.
- To deliver a financial reduction across the CCG for 14/15.
- Participate in collaborative procurement of new pathology provider across Coventry and Warwickshire

7.9 Ambulance Service

The Commissioners are keen to work with the West Midlands Ambulance Service in order to achieve the following for the Contract 2014/15:

- To continue to improve call triage and clinical treatment advice to ensure the correct response for patients. To improve "hear and treat".
- To work with trusts to resolve where possible delays in turnaround times, to follow up and seek advice from other Trusts on their reduction and resolution in delays.

- Reduce conveyance to Emergency Departments unless clinically necessary. To seek other services input that would be more appropriate for the patient.
- To promote the 111 service where appropriate.

7.10 Locally Enhanced Services

WNCCG is currently reviewing all locally enhanced services (LES) and will commission services in line with this review for 2014/15.

7.11 Information Management & Technology

Appendix 1 details the IM&T commissioning intentions for 2014-15.

8 Timetable

The following details the timetable for an agreed contract by no later than 31 March 2014 (or earlier if instructed to do so):

Date	Action
30 September 13	Commissioning Intentions sent to providers Counting and charging letter received from providers
7 October 13	Second draft of new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes (90% complete) to be submitted to Director of Commissioning for discussion at Integrated Delivery Board on 16 October 13
14 October 13	1st draft of WNCCG medium term financial plan to confirm the likely QIPP gap Governance arrangements to oversee planning process in place (e.g. QIPP & CQUIN Technical Groups)
16 October 13	Second draft of new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes (90% complete) discussed at Integrated Delivery Board
24 October 13	Practice Managers Forum discussion and engagement on commissioning intentions/plans
November 13	Practice Forum Group discussion and engagement on commissioning intentions/plans
11 November 13	Final new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes to be submitted to Director of Commissioning for sign off at Integrated Delivery Board on 20 October 13 – to enable discussion with providers
20 November 13	Final new QIPP Plans for 2014/15 (including proposed CQUIN schemes) and revised plans for continuation of existing QIPP schemes signed off at Integrated Delivery Board – to enable discussion with providers
October - December 13	Contract Negotiation Principles Workshop – CCG and Provider Develop financial and activity modelling outputs to support individual CCG baselines per contract Develop QIPP proposals including financial and activity modelling Develop CQUIN schemes Contract negotiation meetings
Mid December 13	Publication of National Operational Framework (tbc) plus publication of national tariff and refresh of headline and supporting indicators
End December 13	Confirm individual CCG baselines
End December 13	QIPP plans signed off with leads identified Confirm individual CCG baselines CQUIN agreed Activity and financial modelling
10 January 14	Formal Contract offer issued to Provider
January – March 14	QIPP implementation phase
31 January 14	Activity & Finance and Terms and Conditions to be agreed and confirmed
February 14	Executive to Executive escalation meetings (if required)
28 February 14	All contracts to be signed (in line with contract agreement in January)

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Appendix 1: COMMISSIONING INTENTIONS for 2014-15 – Information Management and Technology

This section sets out key broad areas where the CCG expects providers to progress information technology developments to improve the efficiency and quality of care. These include collaborative developments across the health economy and provider-specific developments.

The CCG expects to work with providers over the next period to develop more specific plans which can be formalised as contractual commitments where appropriate.

Providers are expected to work collaboratively with commissioners to:

1. Ensure that key national and local systems currently being implemented are fully exploited to deliver efficiency and quality benefits. These include:
   - Electronic Palliative Care Co-ordination System
   - Summary Care Record
   - Electronic communications between Trusts and GP Practices
   - the IT products of the Warwickshire Common Assessment Framework programme
2. Develop and implement new national IT solutions , and comply with national IT targets and guidelines including:
   - NHS e-referrals service (Choose and Book replacement), to make e-referrals available to patients and health professionals for all secondary care by 2015
   - safe digital record keeping as a precursor to achieving integrated digital care records across the health and care system – using the approaches and standards set out in 'Safer Hospitals, Safer Wards: Achieving an Integrated Digital Care Record'. This should include implementation of electronic prescribing capabilities consistent with Section 5.2 of 'Safer Hospitals, Safer Wards' which will also enable the sharing of patient medication records across care transitions
   - where Providers proceed to implement Lorenzo, maximise opportunities for Lorenzo to support integrated care
   - wherever possible digital access to services, in particular the 10 high impact digital initiatives set out in 'Digital first: The delivery choice for England's population'
   - appropriate use of digital technologies to improve efficiency including those set out in the 'Digital Technology Essentials Guide'
3. Continue to work with LHE partners to identify and implement solutions to :
   - wider sharing of patient records across care settings to support integrated care, working towards national target of ensuring that integrated digital care records (IDCRs) become universally available at the point of care for all clinical and care professionals by 2018
   - patient / carer tools to support self-care, collaborative care and healthy lifestyle, including access to records
   - shared business intelligence / analytics across commissioners and providers where practical
   - Consistent approach to messaging and infrastructure.