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NHS COVENTRY & RUGBY

CLINICAL COMMISSIONING GROUP

COMMISSIONING INTENTIONS

2014/16

Date: 30th September 2013

Status: Draft – For further review by Members subject to submission to Governing Body in November for approval.

INTRODUCTION

This year (2013/14) is the CCG's first year of operation as a statutory commissioning body and in line with the ethos of CCGs as membership organisations, local priorities for action have been developed in partnership with member practices and their localities and patients and public from across the CCG area. The process through which these priorities were developed included consideration of the Health and Wellbeing Strategies for Coventry and Warwickshire, the plans and proposals in respect of People services in Coventry City Council and Warwickshire County Council and the emerging priorities for NHS England.

Through an on-going process of engagement, over 1000 patients and members of the public have identified their priorities for action in respect of the five strategic priorities of the CCG:

- Best practice in acute hospital care
- Wellbeing of people with mental health needs
- Health of (frail) older people
- Healthy living and lifestyle choices
- High quality, safe GP practices

During August 2013, the process was repeated at three separate workshops involving representatives from member practices in each of the CCGs three localities along with CCG staff and key staff from the two local authorities.

From these engagement activities, six work programmes have been selected as those likely to make the most significant contribution to improving health outcomes for our population. Over the coming months, the CCG will engage with a wide range of stakeholders to develop ideas as to what changes should be made to existing services within each of these seven work programmes in order to improve the health outcome secured. These ideas will then be reviewed for do-ability and likely impact and the resultant prioritized set of actions will be detailed within the CCG's Operational Plan 2014-16.

Whilst this document details our priority workstreams, we will of course continue to make progress across our entire service portfolio as we seek to secure the best possible mix of services to meet the needs of the population we serve. Further we will work closely with Public Health and Local Authority colleagues to make every effort to reduce acknowledged health inequalities.

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Given the continued constraint on public sector spending, the financial context for 2014/15 and future years will be extremely challenging. Meeting increasing demand with a static resource will require the CCG to work with its members its public and service providers (new and existing) to innovate and to deliver services differently. At the same time we are adamant that reducing costs will not be at the expense of maintaining acceptable levels of safety, quality and patient experience. Locally and nationally, the NHS is managing the impact of constrained public spending and a funding settlement that is more challenging than many can remember. It is likely that all organisations will need to make bold and difficult decisions. CRCCG will ensure that any such decisions are taken only after an explicit consideration of the impact on quality, safety and patient experience and an open discussion with our public and our other local stakeholders.

All of the above combine to create a significant challenge for a relatively new organisation but one that we are committed to facing with boldness, integrity and endeavour.

Our six selected priority work programmes are as follows:

	HEALTHY LIVING & LIFESTYLE CHOICES	PRIMARY CARE QUALITY	FRAIL OLDER PEOPLE	MENTAL HEALTH	ACUTE HOSPITAL CARE
Diabetes	√	√			√
End of Life		√	√	√	√
Dementia		√	√	√	√
24/7 Urgent Care	√	√	√	√	√
Stroke Care	√	√	√	√	√
Children 0-5 years	√	√		√	

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CRCCG COMMISSIONING PRIORITIES FOR 2014/16

1. CRCCG Work Programme: Diabetes Management

In 2002, the Department of Health estimated that 5% of total NHS expenditure is used for care of people with diabetes. This figure is now believed to be closer to 10% of total NHS expenditure which equates to £9 billion per year. People with type 2 diabetes have a risk of death from cardiovascular causes that is two to six times that among people without diabetes.

Structured, systematic care for people with type 2 diabetes aims to minimise the risks from disease – related vascular complications such as cardiovascular, eye, foot and kidney disease. The National Institute for Health and Care Excellence (NICE) has produced quality standards for the clinical management of diabetes in adults which map onto the five key areas of care i.e. structured education, lifestyle and self care, blood glucose control and insulin therapy, management of complications, hospital and emergencies.

Desired changes:

- Enhanced patient awareness and greater support for Self-Care
- 9 annual checks – improved primary care attainment
- Community consultant led diabetes service – providing support to improve the quality of diabetes care in primary care and reducing variation
- Reduction in out-patient activity that will be delivered via a different model in the community
- Use of technology (Diabetes Manager) to risk stratify diabetes patients and provide virtual clinics

2. CRCCG Work Programme: Dementia Care

Dementia is increasingly one of the most important causes of disability in older people. There are around 800,000 people with dementia in the UK, and the condition costs the economy £23 billion a year. By 2040, the number of people affected is expected to double - and the costs are likely to treble. A quarter of hospital beds are occupied by people with dementia. Early identification can

dramatically improve quality of life for people with dementia but at the moment, the diagnosis rate is less than 50%.

The Prime Minister's Dementia Challenge launched in March 2012. It sets out plans to go further and faster in improving dementia care, focusing on raising diagnosis rates and improving the skills and awareness needed to support people with dementia - and their carers.

Both Coventry and Warwickshire have 'Living well with Dementia' strategies and the CCG will work with its two Local Authority partners and other stakeholders to develop implementation plans to secure the desired outcomes detailed in those strategies.

Our focus will be on:

- Increased early diagnosis and intervention
- Automatic contact from post-diagnostic support services
- Greater use of assisted technology
- Enhanced support for Carers
- Improved end of life planning and care
- A consistent specification and quality framework for dementia care providers

3. CRCCG Work Programme: 24/7 Urgent Care

NHS urgent and emergency care services provide life-saving and life-changing care for patients who need medical help quickly and unexpectedly. We know our accident and emergency departments are under increasing pressure and we want to improve the urgent and emergency care system so patients get safe and effective care whenever they need it.

Initial reports from the national review of urgent and emergency care have identified a number of issues which we believe are also pertinent to modernising and improving our local urgent care system. For example, the national review identifies that in some cases, such as heart attack and stroke patients get better outcomes by going straight to specialist centres and not to A&E.

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The review also highlights that some people who present at A&E, and who we treat there, would have more appropriate care and a better patient experience if they were seen in a primary or community care setting. These may be people with long term conditions that need careful management, or people who are having problems getting an appointment at their local GP surgery.

The review further acknowledges that patients find it hard to navigate between primary care, our hospitals and social care services. In many cases some of our most vulnerable patients e.g. frail elderly, need careful management and input from a number of different agencies and sometimes they, or their carers, are just not able to understand and work with this range of services, and find themselves in A&E as a last resort.

All of these issues featured large in the engagement events with member practices, patients and the public.

Our focus is likely to be on:

- Increased emphasis on prevention and self-care
- Further development of our integrated practice teams with their focus on keeping people out of hospital
- Assurance that clinical safety within our hospitals is maintained throughout the 24 hour period, seven days a week
- Sharing of clinical information to support better decision making by emergency teams
- Working with our CCG members to ensure maximum benefit is secured from available primary care resource
- Increased access to community and social care services in the evening and at weekends
- Increased support to care homes to avoid unnecessary hospital attendance
- Re-specification of Out of Hours services
- Work with Primary Care commissioners to review the role of the Coventry Walk in Centre.
- Review of the Rugby Urgent Care Centre

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4. CRCCG Work Programme: End of Life

The CCG is committed to supporting every individual and their family to retain their personal dignity, autonomy and choice throughout the care pathway towards the end of their life.

Nationally, there is a disparity between preferences expressed by the majority to die at home or in a hospice and the numbers actually dying in hospital (58% of all deaths); this is replicated locally (59.1% Coventry and 55% Warwickshire). In the case of people with dementia, the vast majority die in a care home whilst the vast majority of deaths from heart disease or pulmonary disease occur in hospital and the majority of these will have been admitted from their own home (including a residential care home) in the final week of life.

Care at the end of life has been recognised as making up a significant proportion of all health care expenditure in the NHS; research indicates that inpatient hospital care increases sharply at the end of life, particularly in the final two months.

Our focus is likely to be on:

- Extended use of advance care planning
- Implementation of shared care plans accessible by all service providers to ensure good co-ordination of care
- Extension of Hospice at Home to provide support to community (and patients in care homes)
- Strengthening of integration across health, social care and voluntary sector

5. CRCCG Work Programme: Stroke Care

Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year more than 110,000 people in England will have a stroke, which costs the NHS over £2.8 billion.

The most important care for people with any form of stroke is prompt admission to a specialist stroke unit. Everyone who could benefit from urgent care should be transferred to an acute stroke service that provides 24-hour access to scans and specialist stroke care, including thrombolysis.

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Successful stroke services are built around a stroke-skilled multi-disciplinary team that is able to meet the needs of the individuals. Intensive rehabilitation immediately after stroke, operating seven days per week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or care home, ensuring that health, social care and voluntary services together provide the long-term support people need, as well as access to advocacy, care navigation, practical and peer support.

Improvements we are looking to secure:

- Improved primary prevention
- Improved outcomes of stroke patients, by reducing the levels of death and disability following a stroke
- Reduced length of stay of stroke patients in bed based services
- Social care staff better supported to care for stroke survivors

6. CCG Work Programme: Children 0-5 years

Our Coventry population is a relatively young one (compared to the national average) and there has been a rapid increase in the birth-rate both within the most deprived communities of Coventry and within Rugby.

Focussing on the first few years of life is crucial to preventing many of the problems that will affect children as they grow up and in their later life. Working with other commissioners of children's services, most notably Public Health, we want to support families to help their children to have the best chances for a long and healthy life. We need to provide this support early as we know that the earlier it is provided, the bigger the impact.

Subject to further dialogue with commissioning partners, our focus as a CCG is likely to be on:

- Further reductions in smoking in pregnancy
- Reducing other antenatal risk factors (including alcohol, mental health and domestic violence)
- Strengthen safe guarding arrangements including the sharing of information across agencies
- Looked After Children
- Reduction in avoidable short stay emergency admissions

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OUR CORE COMMISSIONING PRINCIPLES

All of our commissioning activities will be undertaken with the intention of assuring Quality & Safety, promoting Integration and securing Best Value.

I) Quality & Safety

The quality and safety of clinical services is an essential element of all service reviews and developments. The learning from recent independent inquiry's such as Francis have highlighted the importance of Q & S being central to the development and monitoring of care delivery. To drive up quality we propose that each commissioning priority has an identified clinical lead and GP commissioning lead, this will also support the drive for greater integration. It is also essential that all developments meet NICE quality standards and follow NICE clinical guidelines. It is the intention to establish clinical networks to support the development and implementation of commissioning priorities.

CRCCG believes the highest quality care is often the most cost effective. Focussing on quality and safety – for example minimising health acquired infections, drug errors and delayed discharges – can improve cost effectiveness. Further, there is still much unexplained variation in clinical practice and clinical outcomes and we will be working with our provider organisations to reduce this variation and to implement acknowledged best practice within available resource. Where appropriate we will use CQUIN and other contractual levers to incentivize quality improvements / desired changes in clinical practice.

II) Integration

National Voices, a coalition of health and social care charities, has identified the lack of joined-up care as a source of huge frustration for patients and carers and has said that "achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety". National Voices has reported that "people want to experience seamless care, where it comes from is secondary". Linked to this, a key recurring theme from our local discussions with our members and our public has been the need to share patient records and care plans to improve the co-ordination of care.

The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand

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driven pressures on services. Any reduction on local social services is likely to result in an increased pressure on health services. To make a real improvement to the care people receive, and to secure maximum benefit from the combined health and social care spend, we have to change the way we do things in the future, and ensure care is provided at the right time, in the right place.

As a CCG we will intend to support integrated care by:

- bringing together providers and commissioners to look at how we can spend our money to the best effect
- promoting the appropriate sharing of clinical records
- Further development of our integrated practice teams
- increasingly contracting for integrated pathways of care

The Integration Transformation Fund announced in the Spending Round should provide an additional focus to making integrated working a reality. The ITF is intended to 'provide an opportunity to transform care so that people are provided with better integrated care and support'. In their joint statement on the ITF, NHS England and the Local Government Association state that "Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives." The £3.8bn of NHS resources that will transfer into the ITF nationally is not new money; it is money that is already being spent on a range of services. Our joint challenge over the next 12 to 18 months is to agree the system/pathway changes that will enable spending to be redirected from treatment services to preventative care and hence reduce the overall cost of provision. To achieve this, statutory partners need to work together to make finance an enabler rather than a barrier to change. As above, as a CCG we are committed to providing resources to pump-prime agreed service changes but we will only be able to do this if our service providers work with us and accept a joint responsibility for overall cost containment.

III) Best Value

The CCG is aiming to achieve a position where it is assured that its level of investment in each service type is appropriate to the quantity and quality of service being delivered. At the same time, we recognise the need to reduce the reliance on urgent care systems and to better manage activity flows into and out of secondary care. Accordingly, we want to move to a position where there

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is a common understanding of the relative cost and productivity of each service and a joint commitment to using that knowledge to shape a more sustainable system for the future. This will of course require a high degree of trust and transparency and may require investment in some services and disinvestment in others. Within this context, we appreciate the need for each organisation to deliver its own financial duties and risk rating. It is not in our interest to create instability within a key partner organisation. Our belief is that long term financial sustainability is best achieved through all health and social care organisations working in a more collaborative and transparent manner, recognising a mutual dependency. This approach is consistent with the emerging Integration agenda.

The CCG will expect Providers to absorb all internal cost pressures within existing funding levels (less the national tariff adjustment).

We would discourage Providers from pursuing counting and charging changes which would result in a net effect that commissioners pay more for the same. Whilst we understand the attraction of this approach, our joint emphasis must be on reducing not maintaining or increasing overall costs. The CCG would wish to use any available investment funds to support pathway redesign and associated non-recurrent restructuring costs.

CRCCG PROPOSED QIPP SCHEMES FOR 2014/15

We will be maintaining and where possible, up-scaling the QIPP schemes we have been pursuing in 2013/14. However, the scale of financial challenge facing the CCG for the foreseeable future requires additional schemes to be identified. Proposed schemes for 2014/15 (in addition to our six priority work programmes) are shown below; these will be revised as detailed project plans are developed and tested.

We would also invite Providers (new and potential) and other Stakeholders to put forward proposals as to how services could be delivered more cost effectively. Funding for new investments is limited but all Invest to Save proposals that have the potential to deliver savings to commissioners will be given due consideration.

Existing Schemes	Proposed Schemes
• GP Referral Management • GP Prescribing • Specialist Prescribing • MH Out of Area Placements • Continuing Healthcare • Procedures of Low Clinical Value • Orthopaedic Procedures • Effective Discharge (XBDs) • Avoidable Admissions ➢ Integrated Practice Teams ➢ COPD ➢ Heart Failure	• Falls Prevention • Surgical Thresholds • Dermatology • Pathology • Outpatient Pathways • CCG Running Costs • Avoidable Admissions ➢ End of Life ➢ Care Homes ➢ Vaccine Preventable

CRCCG POTENTIAL PROCUREMENT ACTIVITIES FOR 2014/15

Planned Procurements:

- Termination of Pregnancy Services
- Primary Care Enhanced Services
- Individual Patient Packages (Residential and Home Based nursing care)
- Pathology
- NHS 111 (regionally led)

The CCG is currently reviewing the following services. The outcome of those reviews will inform in-year procurement decisions and timelines:

- Improving Access to Psychological Therapies
- iMSK
- Out of Hours
- Walk In Centre (potentially via NHS England)

The CCG reserves the right to initiate additional procurements at any time.

The three CCGs within Coventry & Warwickshire have articulated a joint intention to explore and implement new approaches to contracting and procurement in order to encourage innovation and collaboration within and

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across the Provider landscape. We will be looking to develop service specifications based on outcomes (see below) and to using, where appropriate, approaches such as competitive dialogue and lead contractor models to secure effective supply chains capable of delivering these outcomes in a patient centred and cost effective manner.

COMMISSIONING FOR QUALITY & IMPROVED HEALTH OUTCOMES

CCG commissioners are held to account for improving health through the NHS outcome frameworks. We believe that our six priority workstreams will deliver significantly improved outcomes across each the five domains:

NHS Outcomes Framework					
	Preventing people from dying prematurely	Enhancing quality of life for people with long term conditions	Ensuring that people have a positive experience of care	Helping people to recover from episodes of ill health or following injury	Treating and caring for people in a safe environment and protecting them from avoidable harm.
Diabetes Care	√	√	√		
Dementia Care		√	√		√
End of Life Care		√	√		
24/7 Urgent Care		√	√		
Children 0-5	√		√		√
Stroke Care	√			√	√

It is understood that the role of CQUIN payments is being reviewed nationally and that they may not necessarily operate in the same way as previous years. Assuming that locally determined quality payments continue in some form, our intention is to focus on a small number of high impact schemes for each Provider contract.

It is anticipated that as in 2013-14, the majority of CQUIN schemes will support the implementation of agreed QIPP initiatives and key areas of clinical need identified in year as requiring major improvement.

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Subject to any emerging national guidance, Coventry & Rugby CCG would wish to see at least one collaborative CQUIN where achievement is dependent upon collaboration across the Acute and Community interface and delivery of an economy-wide quality improvement.

INFORMATION & COMMUNICATIONS TECHNOLOGY (ICT)

Providers are expected to work collaboratively with commissioners to progress information technology developments that improve the efficiency and quality of care. These include collaborative developments across the health economy and provider-specific developments.

Providers are expected to work collaboratively with commissioners to:

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

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'

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.

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