NHS
South Warwickshire
Clinical Commissioning Group

Commissioning Intentions

2014-15

better healthcare for everyone

1 About This Document

Our commissioning intentions for 2014/15 are a more detailed focus on year two of the NHS South Warwickshire Clinical Commissioning Group (CCG) Integrated Plan 2013-16 (the 'Integrated Plan').

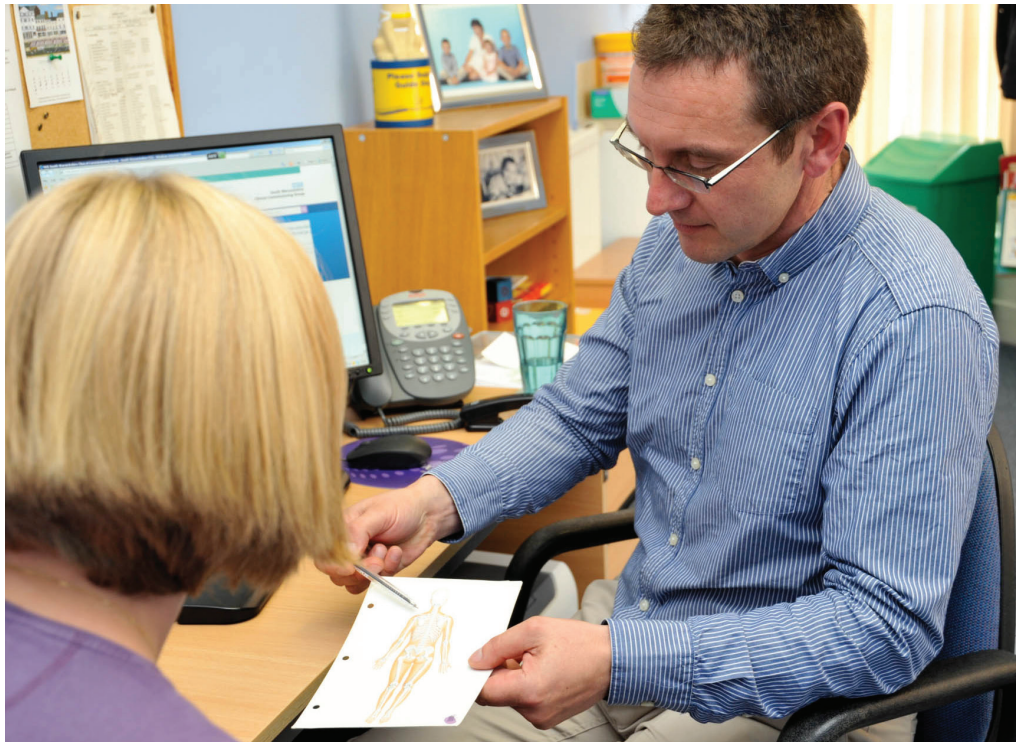
We have continued with our commitment to engage with our partners. We have held a series of engagement events with public and patient groups, the South Warwickshire CCG Members' Council, the voluntary sector and providers to develop this document.

Since the approval of the Integrated Plan there have been some changes to our financial planning assumptions which we have outlined in section two.

The Integrated Plan has transformation of the urgent care system at its heart. During 2013/14 we recognised that we needed to describe our vision for the urgent care system more clearly. Section three outlines our approach, highlights our early successes and the key changes that we want to make in 2014/15 and beyond.

In response to the changing environment we have established a new style of working to deliver the changes outlined in the Integrated Plan at greater pace, scale and with an increased level of grip. In section 4 we outline the three priorities which will enable us to deliver the changes at the pace required.

Finally in section 5, we provide detailed information on the specific changes that will need to be reflected in provider contracts for 2014/15. Where possible, changes will take effect from the 1st April. However, some schemes will require in year changes to contracts following procurement processes.



2 What to expect in 2014/15

The financial context for 2014/15 and future years will be extremely challenging. National changes to what is classified as a specialised service mean that we no longer commission services for some patients and instead NHS England does that for us on a larger footprint. As a result of these changes we have experienced a greater reduction in our budget than we had planned for when the Integrated Plan was developed. This means that we have several millions of pounds less than we had originally planned for 2014/15.

A requirement for greater integration between health and social care will lead to an expansion in pooled funding arrangements. The social care budget is likely to be significantly reduced in the forthcoming years so we need to work together to commission services that meet both health and social care need.

The Transformation Integration Fund provides us with new opportunities to commission integrated care for our population; however, there is no new money to fund this transfer. We will therefore need to reduce health spend in other areas to release the money that will be required to deliver pooled funding arrangements.

To meet these challenges the CCG will commission models of care that enable a growing demand for health services to be met at the same, or lower cost, than current models of care. Any new additional investment will therefore be limited to mandatory service developments only e.g. NHS 111.

There will be an increased focus on the value for money (quality, cost, performance) of each and every service offering. This will result in the expansion of those services offering good value for money and disinvestment from those that do not. Market testing and procurement will feature more heavily than in the past as a tool for realising innovation and value for money.

The value for money agenda will extend to the CCG itself and there will be a focus on reducing CCG running costs to release resources to pay for health care.

All this indicates that in order to achieve financial balance, NHS South Warwickshire CCG will need to adopt innovative ways of working to ensure clinical and cost effective, quality care for patients.

Our provider organisations should expect:

- ✓ Contract values in 2014/15 to at best be no greater than those of 2013/14;
- ✓ To be challenged on value for money of their service offerings;
- ✓ To work with the CCG to deliver innovative solutions that address demand pressures at the same or lower cost;
- ✓ To respond positively to an increased requirement to compete for future contracts

3 Creating a sustainable urgent care system

During 2013/14 there has been an increased focus on urgent care at both a national and local level. In response to this we have established a South Warwickshire Urgent Care Board (UCB) which brings together partners from the health and social care economies in south Warwickshire. The UCB will oversee the delivery of all urgent care initiatives across the south Warwickshire system.

In order to provide clarity on how our Integrated Plan will deliver a sustainable urgent care system we divided it into four key components and mapped our Quality Innovation Productivity and Prevention (QIPP) schemes onto the four areas.

The following points explain the four components; describe the changes we have made and want to make in the future and the actions that we will take during 2014/15.

Prevention and Self-Management

Individuals, families, carers and communities need to play their part in ensuring that the urgent care system in south Warwickshire is sustainable. Alongside Local Authority partners we are committed to supporting communities build support networks and create a sense of collective responsibility for health and wellbeing.

During 2013/14 we set ourselves the target of recruiting 1% of our population as **health champions**. We are making good progress towards this and the number of 16-18 years olds who have joined is extremely encouraging. For 2014/15 we will aim to recruit 3% of our population.

We set ourselves the target of reducing paediatric admissions by 3%. We will be buying **self-help books for all new parents and a web package** which will help them look after their children at home for 2014/15.

In collaboration with Warwickshire Public Health, 9,600 people aged 40-74 will be offered a health check each year, with the remainder of the eligible population being offered a **health check** within the next five years.

In 2014/15 we will continue to progress our work on **Building Social Capital** working with Local Authority colleagues to develop improved relationships with the voluntary and community sector and develop new approaches to working with the local population.

Loneliness is one of the major underlying causes of ill health. Work has already commenced in 2013/14 and **Combating Loneliness** will be a significant project within our work programme next year.

We invite patient group chairs from all 36 practices to monthly meetings to discuss key issues. Discussions about the urgent care system highlighted the challenge norovirus gives the system. Motivated to make a difference the patient group is planning a **hand washing campaign**. Supported by Public Health, environmental health and the Warwickshire County Council Education Team they are going to work with schools and employers to improve how people wash their hands.

Improving the management of long term conditions/high need patients

We have made significant progress in the last 12 months on improving the co-ordination and quality of care for our most vulnerable and complex patients.

With Warwickshire County Council we have been working with all 26 nursing homes in south Warwickshire to improve the quality of care and 'up skill' staff in nursing homes. We have recruited a team of specialist nurses who are giving additional training and support to nursing home staff. It is anticipated that from November 2013 all 26 nursing homes will have enhanced GP cover which will mean that nursing patients all have advanced care plans and have more frequent input from a doctor than they have had previously.

In collaboration with social care we will start a process in October 2013, to procure support tailored to residential homes. We aim to have a new service in place by 1st April 2014.

We want to improve the quality of End of Life (EoL) services for our population. On the basis that each year 1% of our population dies, we want our end of life registers to reflect this. By March 2016 we want 0.8% of our population on an End of Life Register.

Significant work is being undertaken by our member practices and by the end of 2013/14 we will be implementing the following initiatives to improve EOL services:

- Gold Standards Framework Primary Care Training Programme;
- Electronic Palliative Care Co-ordination System (EPaCCs);
- The Route to Success in End of Life Care in our 26 nursing homes;
- End of Life best practice tools in primary care and nursing homes and;
- We will have awarded and mobilised a contract for a practice development team.

Work has also been undertaken by South Warwickshire Foundation Trust on workforce integration and implementation of telehealth.

Whilst these have been positive steps, partners across the system recognise that the current contractual structures do not always facilitate professionals to work in the best interests of the patient.

Our member practices believe that there are more innovative and effective ways of delivering services in the community that will deliver person centred care. They want improved relationships with community staff, in particular the district nurses. In the short term this will be delivered through an existing workforce integration and hub redesign project. In the longer term, we will collaborate with Warwickshire County Council to **commission a new service for long-term conditions and those patients with complex needs.** This will include mental health and dementia but not children's' services in the first instance. This will not have any contractual impact on providers during 2014/15 but is likely to impact in 2015/16.

Whilst work is underway to commission new services we want to continue to make progress towards delivering more integrated, person centred care. Therefore during 2014/15 we, and social care, will be aiming for all individuals aged over 75, and/or those with multiple long term conditions, to have **person centred goal setting and a care plan** put in place that is accessible to all professionals within the system. We are currently undertaking initial scoping and expect to be able to share our approach with providers and other partners in October.

From 2014/15 we will be making Personal Health Budgets available from within our Resource Allocation Policy to patients who are eligible for Continuing Health Care.

We also believe that there are opportunities to transfer outpatient activity for long term conditions back to primary care and deliver improved outcomes. Starting with Diabetes we are exploring how primary care could manage more diabetics with support from Diabetes Consultants. We would however wish to continue to refer patients into secondary care for the '**Super 6**':

i. Antenatal Diabetes;
ii. Diabetic foot care;
iii. Renal (estimated glomerular filtration rate <30);
iv. Insulin pumps,
v. Type 1/adolescent diabetes (unstable control)
vi. Inpatient Diabetes care

Discussions are at an early stage but we have made good progress and would hope that we are in a position to make these changes during 2014/15.

We will be expanding this to other long term conditions and Mental Health Clusters 1 (Common Mental Health Problems, low severity), 2 (Common Mental Health Problems) and 3 (Non-psychotic, moderate severity).

Admission Avoidance

Over recent years we have made inroads into admission avoidance. The **Community Emergency Response Team** (CERT) has been operational for several years, improved psychiatric liaison is now in place and there has been improved use of **ambulatory pathways**.

However, discussions with our member practices have revealed that many of the options available to them are not designed to support them in the community when patients first start to show deterioration. This primarily relates to those with long term conditions and complex needs but analysis of A&E attendances and emergency admissions, undertaken for the South Warwickshire Urgent Care Board, has demonstrated that we need an improved community urgent response service for all of our population.

By November 2013 we will have commissioned an **Admission Avoidance Programme** (Phase 1) to keep people at home. This will provide patients with access to specialist opinion and/or diagnostics within 24-48 hours for patients.

In November 2013 we will start the more comprehensive **Admission Avoidance Programme** (Phase 2). This will impact on services outside of the hospital and is anticipated to significantly change the number and type of contracts we have with providers from April 2015.

NHS 111 is an important part of the urgent care system and we continue to work collaboratively with CCGs in the West Midlands to secure a sustainable service for our local population.

Supporting Discharge

Our major focus in 2013/14 has been the progression of the Discharge to Assess service. The service is still being piloted but the early results are extremely encouraging. The data generated from the pilot will inform a business case that will set out the capacity required within care homes and support resources. The Governing Body will consider the full business case in January 2014.

The actions for 2014/15 have all been mapped against the Integrated Plans aims and objectives which can be found in section 5.

4 Making the Integrated Plan Real

Our approach to delivering the Integrated Plan during year one was on an individual projects basis. These projects were designed to change elements of services within the framework of our existing contracts. Whilst this approach has delivered changes to the care delivered to our local population it is not delivering change with the pace, scale and grip that we want.

To create a step change we have identified three priorities which will enable us to deliver change at pace but also reflect a level of pragmatism about what is achievable. We will start working in line with these priorities from September 2013.

Within these priorities we have provided examples of the projects that would be delivered within each of the three approaches. Many of these have been described in the previous section but we will of course deliver improvements in all parts of the system; not just urgent care.

Priority One: Commissioning for Health and Social Care Outcomes

The Transformation Integration Fund provides us and social care with significant opportunities to deliver integrated health and social care. We have had a number of very positive discussions and will be sharing a first draft of our plans with the Health and Wellbeing Board in November.

We will develop new types of contracts (Outcome based) for NHS and non-NHS providers so that providers are incentivised to work together to provide person centred care. Central to this approach will be the shift to commissioning by outcomes. In partnership with Warwickshire County Council we want to ensure that payments to providers are based on supporting people to attain their personal goals rather than what professionals and organisations believe to be what the individual needs.

Public and Patient involvement is essential in developing our priority areas and ensuring this approach to commissioning is effective. We will be seeking to maximise the already well-established engagement routes to tap into the energy and enthusiasm so many of our local residents have, in order to support us as organisations make things better for the local population.

In order to identify areas where we can make the largest impact, we will be developing a two year work programme for Older People, Mental Health/Learning Disabilities and Children. We will be jointly engaging with providers and the local population on the areas that would benefit most from joint commissioning during Autumn 2013.

Increased integration will require professionals to work in a different way – both between members of their own profession and with those from other professions. We will foster a proactive, positive approach to these situations and encourage those who find these changes difficult to focus on the improved outcomes for their clients or patients rather than becoming entrenched in their views. There will be large implications in terms of workforce planning, education and training that we will need to address to ensure that this new approach to work is safe and sustainable.

In commissioning for health and social care outcomes we will be seeking to undertake competitive processes. The joint engagement work and development of our first draft of the Transformation Integration Fund will indicate the areas where we are seeking to implement this approach. However, from existing work we have identified the following areas for 2014/15:

- Admission Avoidance Programme (Phase 2) (Includes Out of Hours (OoH));
- Discharge to Assess;
- Support to Residential Homes;
- Child and Adolescent Mental Health Services (CAMHS);
- Falls Service.

Priority Two: Drive Innovation and Productivity by Going to the Market

This priority again requires a more significant use of competitive approaches and use of the market. The key difference is that within this priority we will seeking to use competitive processes not to provide more integrated care within the same cost envelope but to release money from the system to close the financial gap that we face.

This may be done in conjunction with social care, but will be more typically undertaken in discrete services commissioned by NHS South Warwickshire CCG, and will be characterised through greater use of Any Qualified Provider (AQP).

The details of the proposed procurements can be found in Section 5 where all of our Quality, Innovation, Productivity and Prevention (QIPP) schemes are mapped against the aims and objectives of our Integrated Plan. However, the most significant of these include

- Re-tender Improving Access to Psychological Therapies (IAPT) Services;
- Any Qualified Provider (AQP) for Procedures of Limited Value;
- Rationalisation/retendering of voluntary service contracts in partnership with Warwickshire County Council, Stratford-upon-Avon District Council and Warwick District Council;
- Super 6 for Diabetes;
- Doppler Scanning;
- Locally Enhanced Schemes currently under review.

Priority Three: Systematic Approach to Quality and Prevention

For those services unaffected by large-scale change we still expect continuous improvement and contribution to our strategic plan. This takes the form of quality improvements and actions to support our population to take action to prevent chronic disease. In the main, these improvements will be delivered through contract terms and conditions but some will be QIPP schemes that we will deliver.

As with the previous section we have mapped the details of contractual Terms and Conditions and QIPP schemes onto the aims and objectives of our Integrated Plan.

Quality and safety permeate throughout every aspect of commissioning. We will ensure all providers deliver the expected rights and pledges from the NHS Constitution, comply with national quality standards, such as NICE, and operate to the high standards expected within the NHS.

Safety of patients is our number one priority and we expect our providers to comply with national standards relating to safeguarding vulnerable adults and children, reducing hospital acquired infections and community infections, as well as the Duty of Candour.

We monitor quality by measuring performance against specific quality and performance indicators, serious incidents, clinical audits, patient experience information, morbidity and mortality data and GP feedback. Drawing on the Francis Report and Keogh, we will be increasing the breadth and depth of the sources of quality information and implementing a pro-active visiting programme to our providers. We expect all of our providers to play a full and active role in the prevention of ill health. Stopping and delaying the onset of chronic disease is the basis of a sustainable health and care system.

Making Every Contact Count (MECC) ensures that providers take every opportunity to support people to make informed lifestyle changes are taken. MECC will be embedded in all of our service specifications and providers will contractually be required to have a trained 'MECC Champion' in each clinical area or nursing team. Each provider needs to have a clear action plan to achieve rolling out of MECC to all front-line clinical staff by March 2018.

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. We have therefore developed a set of terms and conditions that we want reflected in contracts with providers that will deliver reduced levels of smoking in patients with mental illness and for women who are pregnant. In addition to a focus on smoking, all maternity providers are to develop and implement a maternal obesity pathway by March 2014.

Providers need to ensure that they encourage all staff to have their flu vaccinations; provide vaccinations to long-stay in-patients and encourage all patients, but especially pregnant women, to attend their own GP practice for their flu vaccination.

Providers should be able to assure themselves and us that they proactively and robustly ensure that all frontline and clinical staff have evidence of immunity to measles.

Increasing initiation of breast feeding has been a requirement for a number of years. All maternity providers need to have achieved Baby Friendly Initiative stage 3 achieved by December 2015 and 75% breast feeding initiation needs to be achieved by March 2014.

As a group of practices we take the ongoing review of our own and peer performance very seriously. Our strength as a CCG is a result of the collective efforts of all 36 practices and we therefore have implemented robust processes to hold each other to account through a GP performance framework. We expect the same commitment to continuous improvement from all clinicians within the system.

We have closely monitored our access rates for elective and non-elective activity for several years, during 2013/14 we expanded this to diagnostics and imaging and in 2014/15 we will include mental health. Outlier practices will be actively reviewed and managed throughout 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 to develop more specific plans which can be formalised as contractual commitments where appropriate.

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 develop :

- 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;
- A consistent approach to messaging and infrastructure.

5 QIPP Schemes and potential contract impacts

This section provides a summary of the QIPP schemes which we anticipate continuing into 2014/15 together with the potential new schemes which we envisage emerging from the themes and priorities identified in the earlier sections of this document. These (*) are in various stages of development and reflect our entire QIPP pipeline. Not all will convert into QIPPs for 2014/15. We have also indicated the potential impact which these schemes could have on contracts. In addition, there is the expectation that all relevant KPIs will roll forward into the 2014/15 contract.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 1: To build relationships with patients and communities			
Improve Communication between organisations and professionals	• Improved Utilisation of Choose and Book; • Development of standards to improve the transfer of information on discharge;	• A&E to notify GP surgery if patient attends A&E during opening hours with minor ailments; • Diversion of patients back to GP from A&E;	• This could potentially impact on SWFT A&E attendances and/or follow-ups; • Providers are expected to work collaboratively with commissioners to ensure that key national and local IT systems are fully exploited to deliver efficiency and quality benefits; • A&E discharge summaries to be received by practices within 24 hours of discharge;
Co-ordinated services for dementia patients and their carers		• Work with practices and third sector to establish self-help meetings for carers of dementia sufferers; • Review and re-commission services for patients requiring an assessment for cognitive dysfunction;	• Impact on CWPT contract could be potential re-procurement of services for patients requiring an assessment for cognitive dysfunction.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
Prevention of admission for the frail elderly through integrated health and social care services	• Discharge to assess (D2A) • Psychiatric Liaison; • Admission Avoidance Programme Phase 1.	• Admission Avoidance Programme Phase 2; • Jointly commission service for long term conditions and complex patients.	• Potential reduction in SWFT emergency admissions; • Potential reduction in SWFT LOS and excess bed days.
Support individuals to die in their place of choice	End of Life Project that includes: • Gold Standards Framework Primary Care Training Programme; • Electronic Palliative Care Co-ordination System (EPaCCs); • The Route to Success in End of Life Care nursing homes; End of life best practice tools in primary care and nursing homes and; • Practice development team.		• All organisations use a common DNAR form that transfers between organisations.
Develop a thriving engagement network	• Health Champions (increased from 1% to 3% of our population); • Self-help tools for parents.	• Reduce vaccine preventable admission; • Rationalise voluntary/third sector contracts; • Hand washing campaign; • Building social capital; • Combatting loneliness; • Reduced obesity related admissions;	• Reduction in Admissions; • Potential reduction in elective activity.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 2: To improve health and reduce health inequalities			
Improve the management of Long Term Conditions	• Ambulatory Pathways; • Health Checks.	• Super 6 for Diabetes; • Personal Health Budgets; • Commission new stroke pathway; • MDT review of patient with long term conditions that have two or more admissions in a twelve month period.	• We want to commission a new model of Diabetes services around the 'Super 6'. We will review the contract impact; • We want to commission a new stroke pathway and we will review the contract impact.
Improve the Choices made by pregnant women	An objective for 2015/16 and 2016/17	• Reduce the caesarean section rate from its level of 27% (21% of first time mums undergoing unplanned sections).	• 100% of women have smoking status recorded at time of delivery; • BFI stage 3 achieved by December 2015 by all maternity providers; • 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.
Stop the trend of increased alcohol related admissions	• Alcohol team in A&E and primary care support;		
Reduce the unplanned variation in Primary Care quality and prescribing	• Primary Care Prescribing; • Reducing variations in referral rates for pathology, diagnostics, electives, A&E attendance and emergency admissions	• Access to Mental Health services.	• Could potentially reduce referrals to mental health services.

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 3: To improve the quality of care and transform services			
Improve the access to Mental Health Services through improved communication between professionals	An objective for 2015/16 and 2016/17	• Retender of IAPT service • Retender CAMHS service • Review maternal mental health services • Reduce self-harm admissions • Review of all patients receiving joint packages of care to ensure services reflect patient needs/goals (includes s117) • Review Learning Disability inpatient pro vision in light of Winterbourne Review)	• Potential impact for CWPT • Potential impact for CWPT • Potential reduction in service levels (CWPT) • Potential reduction in service levels (CWPT)
Reduce avoidable harm	• Contract Terms and Conditions +CQUIN + Quality Metrics	• Commission a falls prevention service jointly with social care.	• Inform SWFT for information
Improved patient experience	• Implementation of patient feedback process/ encouraging feedback • NHS 111 • Domiciliary phlebotomy	• Person centred goal setting/care planning • GP feedback system	
Improve the quality of care of nursing home residents	• Nursing home admission avoidance • Additional medical care to nursing homes	• Commission support to residential homes	• Potential impact on admissions levels

Objectives	2013/14 QIPP SCHEMES THAT WILL CONTINUE INTO 2014-15	POTENTIAL* NEW QIPP SCHEMES FOR 2014/15	CONTRACT IMPACT
AIM 4: To make the best use of our resources			
Providers will have reduced unnecessary steps in their processes	An objective for 2015/16 and 2016/17	• Directly bookable doppler for GPs to reduce/review demand on Deep Vein Thrombosis clinic • Reduce duplication of diagnostics • Improve18 week Referral to Treatment flow and reduce unnecessary steps	• This should reduce non-elective admissions and potentially increase Doppler activity
Adherence to NICE and other evidence based guidance	• High Cost Drugs • Low Priority Procedures (LPP)	• Introduce wound care formulary • Develop a Continence Aid Policy • Develop commissioning policies to reduce procedures of low clinical value activity	• Potential reduction in the number of low clinical value activities
Optimise Continuing Health Care spending	• Mental Health Out of Area Repatriation • Continuing Health Care Reviews		
Commission services within our resource envelope	• Enteral Feeding	• Value for money review of all block and/or non- NHS community and third sector contracts • Price Equalisation in non-NHS contracts • Evaluation of the cost-effectiveness of make, share, buy arrangements (Commissioning Support Services) • Identification of services amenable to AQP	