Central London Healthcare

Commissioning Strategy 2012/13 – 2014/15

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Contents

1. Introduction

- This slide deck is intended to support Clinical Commissioning Groups (CCGs) outline their strategic aims to inform the development of commissioning intentions for NHS North West London (NHS NWL) for 2012/13 – 2014/15.
- Completion of these slides is the formal submission as outlined in the letter from Daniel Elkeles dated 3 August 2011.
- This slide pack contains introductory sections (numbered 1 to 4) outlining the commissioning strategy process and a set of slides for CCGs to complete (numbered 5 to 21).
- When completing slides, CCGs should add as much detail as possible and, therefore, may wish to annex more information. CCGs will need to consider how to present a summary to the CEC and there is a concluding slide (which can be expanded) to summarise the contents as far as possible.
- The next slide outlines in further detail the draft planning guidance NHS NWL has received. There are two key points to emphasise. First is that this process will ensure CCGs shape the Cluster strategy rather than the other way around. Second, on the scale of the task, CCGs are not starting from scratch; the planning guidance outlines that this is a review and refresh of the existing strategy with CCGs outlining where this should change in future rather than development of an entirely new strategy. It should also be noted that CCGs will be able to access support on this work through current Borough and sub-Cluster structures.

2. Planning guidance

- This is taking place at the same time as CCGs are taking on both delegated responsibilities and development towards authorisation. For those services where you have not yet taken on delegated responsibilities, you will need to work with Boroughs and sub-Clusters on these elements of your commissioning strategy. Also, the product of this work will be an important part of your application for delegated responsibilities for medium complexity services that we expect at the end of September.
- NHS London has provided guidance on the development of plans. This guidance recommends that London's 2011/12 plans should:
  - Cover three years from 2012/13-2014/15 to match the planning cycle the NHS CB will adopt
  - Build on years 2, 3 and 4 from current cluster four year QIPP plans
  - Include strategic QIPP and financial plans for the three years. We will be sending out more detailed guidance about the completion of the QIPP elements for completion by CCGs and sub-Clusters shortly.
  - Go into more detail on initiatives and financial and planning analysis for all three years
  - Be developed in a way to meet this year's statutory requirements and provide pathfinders with strategic plans for authorisation.
- CCGs are responsible for ensuring that plans are discussed with shadow Health and Wellbeing Boards. There is also a statutory responsibility to involve patients and the public and there are a number of slides dedicated to this later.

3. Supporting authorisation of CCGs

This section draws together the material developed by DH with pathfinders and other key stakeholders including national subject matter experts, about the kinds of areas that might be looked at through the authorisation process. This material does not represent guidance on what emerging clinical commissioning groups (CCGs) need to do to be authorised, but is a summary of the views represented so far to the DH. It is included in full at appendix 1.

Domain 1. A strong clinical and professional focus which brings real added value

A great CCG will have a clinical focus perspective threaded through everything it does, resulting in having quality at its heart, and a real focus on outcomes. It will have significant engagement from its constituent practices as well as wide spread involvement of all other clinical colleagues; clinicians providing health services locally including secondary care, community and mental health, those providing services to people with learning disabilities, public health experts, as well as social care colleagues. It will communicate a clear vision of the improvements it is seeking to make in the health of the locality, including population health.

Domain 2. Meaningful engagement with patients, carers and their communities

CCGs need to be able to show how they will ensure inclusion of patients, public, communities of interest and geography, health and wellbeing boards and local authorities in everything they do, especially their commissioning decisions. They should include mechanisms for gaining a broad range of views then analysing and acting on these. It should be evident how the views of individual patients from the consulting room are translated into commissioning decisions and how the voice of each practice population will be sought and acted on.

Domain 3. Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national outcome standards and local joint health and wellbeing strategies

CCGs should have a credible plan for how they will continue to deliver the local QIPP challenge for their health system, and meet the NHS Constitution requirements. These plans will set out how the CCG will take responsibility for service transformation that will improve outcomes, quality and productivity, whilst reducing unwarranted variation and tackling inequalities, within their financial allocation. They need a track record of delivery and progress against these plans, within whole system working, and contracts in place to ensure future delivery. CCGs will need to demonstrate how they will exercise important functions, such as the need to promote research.

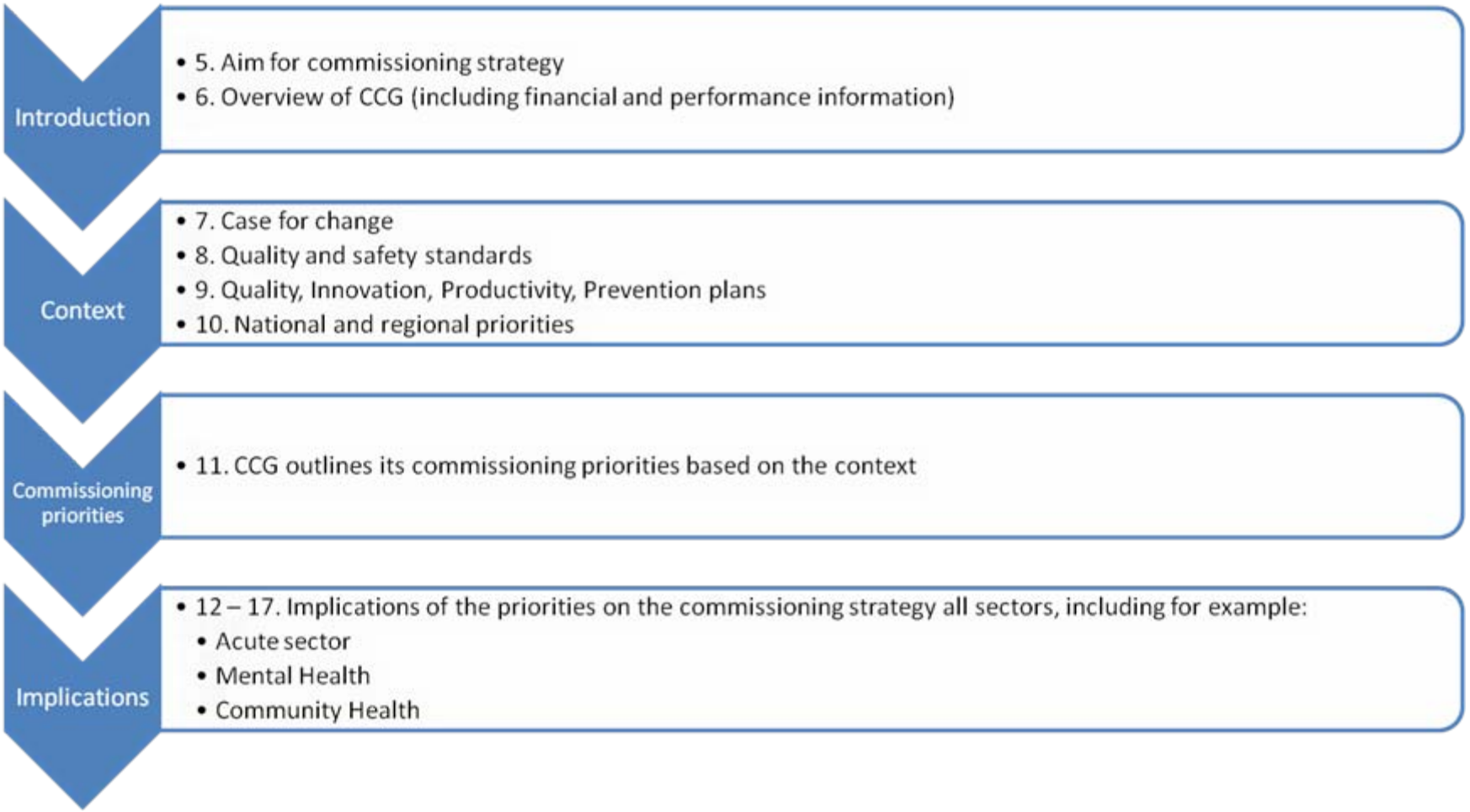
A credible commissioning plan which:

- Outlines the CCG's clear vision owned by patients, constituent practices and stakeholders;
- Demonstrates how the CCG has understood and quantified the health needs of the population (including disadvantaged groups and those not registered with a GP practice);
- Identifies the health inequalities and unwarranted variations that exist and sets out how they will be addressed;
- Sets out how the CCG will deliver continuously improving quality services and value for money, contains well described initiatives linked to the vision and focused on the outcomes to be achieved;
- Demonstrates an understanding of, and plan to improve and embed continual quality improvement across primary care;
- Demonstrates how the CCG will deliver financial balance, all quality outcomes and a reduction in inequalities;
- Demonstrates how the CCG has worked with the whole health system and community to agree the way in which QIPP will continue to be delivered in the relevant parts of the health
- system;
- Demonstrates an understanding of the impact on the provider landscape, and how they are working and will work productively with providers to deliver the local QIPP challenge;

- Gives confidence that the CCG has robust plans to manage demand of acute services, triangulated with quality requirements, workforce capacity and financial allocations; and
- detail around their capacity and capability to deliver;
- Has a set of key performance indicators that will enable the CCG to demonstrate delivery against plan for the QIPP challenge, including demonstrating improved quality and outcomes for patients, and robust arrangements for performance management.

- **Underpinned by:**
  - Planning assumptions derived from the Joint Strategic Needs Assessment and draft health and wellbeing strategy;
  - Rigorous financial management arrangements;
  - Information about explicit investment and disinvestment plans and their impact on quality and outcomes;
  - Appropriate risk-sharing and risk-pooling arrangements;
  - Robust arrangements to test and measure achievement against their plan, including a set of key performance indicators collected and used by the consortium to demonstrate improved quality and outcomes for patients.
- **Examples of evidence CCGs might wish to use to demonstrate their competence:**
  - Their commissioning plan(s), which shows alignment of financial activity, demand management and workforce assumptions;
  - A track record of successful implementation and delivery towards planned objectives within a delegated budget;
  - A track record of improvements in outcomes and value for money since they became a pathfinder, for example a track record in reducing unwarranted variation;
  - Evidence of influence, active participation, whole systems working and impact during previous planning round;
  - Evidence of active implementation of sustainable transformational change objectives within QIPP plans for previous planning round(s) as partners within whole health system working.
  - **Examples of how the NHS Commissioning Board could gain additional insight:**
  - Technical assessment of the commissioning plan(s), and associated documents;
  - Assessment of performance during preparatory phase, including their contribution to delivering the 2011/12 components of the SHA/PCT cluster QIPP plans.

4. A diagrammatic representation for developing the commissioning strategy



Introduction

- 5. Aim for commissioning strategy
- 6. Overview of CCG (including financial and performance information)

5. Aim for commissioning strategy

The aim of a commissioning strategy for NHS NWL is to realise the aspirations of patients, communities, and all stakeholders inside and outside the NHS who want to deliver the highest quality of health care and make the best use of public money. We want to ensure alignment between the strategic objectives for commissioners and providers of health care and the allocation of our financial resource for a sustainable NHS in North West London.

The CCG's aim for a commissioning strategy in their geographical area:

The Central London Healthcare (CLH) strategic plan will have a central and pivotal role in shaping and driving the business of CLH as it takes on new commissioning responsibilities. It will serve as a focus for stakeholder and partnership engagement and commitment to working in an active partnership with our patients and the community to improve their quality of life and wellbeing, to help people live better for longer**.**

The strategy will articulate our undertaking to ensure continual improvement in the quality of health services, prevent illness and promote health, drive greater efficiency and productivity in services and look for innovative solutions to ensure the very best healthcare is available to our patients.

It will form the core of our business and enable robust planning and delivery processes.

In essence it illustrates how CLH will deliver financial balance, deliver safe care and quality outcomes and achieve a reduction in inequalities for the entire CLH population including non registered patients and vulnerable groups.

6a. Overview of CCG

Overview to include (1) a description of the CCG, (2) the CCG's vision for the health of their population, (3) total budget for CCG area by type of spend (acute, mental health etc.) and accountability (specifying CCG delegated budgets).

Central London Healthcare

Central London Healthcare was formed in 2006. It consists of 24 local NHS practices across Westminster who are working together to deliver excellence and innovation in primary care, actively working together to improve services for patients. CLH services approximately 130,000 patients in the Westminster area which represents 60% of the registered population.

40% of the registered population is aged between 25 and 44 years old, 13% are under 15 years old, and 9% are aged 65 and over. CLH has more males aged between 15 and 44 years compared to the registered population of INWL CCGs and fewer females in the age groups covering 25 to 74 years old.

Compared to England, and even compared to London, we have relatively small numbers of children and older people and a very high proportion of our population is of working age.

Nearly 55% of CLH patients come from areas in middle quintiles of deprivation. The largest deprivation group for CLH patients is the third most deprived quintile (Q3). There are no patients from the least deprived areas.

Average life expectancy for both men and women is amongst the longest in the country. Cancer is the major cause of death in CLH patients, making up 33% of deaths in 2009/10 and 2010/11. Circulatory disease makes up 31% and respiratory diseases, 12%. These are also the main contributors to the wide health inequalities seen across Westminster.

Mental Health is of particular importance to CLH, there are high rates of suicide and substance misuse and isolated elderly residents living with dementia.

The Vision

The CLH vision is one of patient focused GP and patient led commissioning leading to:-

•Better **integration** of primary care with secondary healthcare, social care, services in the community and the voluntary sector. Integrated Care Pathways (ICP) will be the key focus with increasing GP engagement and an expansion of disease pathways.

6b. Overview of CCG cont.

The Vision continued:

•A system that delivers **recovery focussed patient outcomes** and meets users' wishes i.e.

- ✓ Easy to Access (**values patients time**)
- ✓ Provides **equity** of access
- ✓ Well **coordinated** and provides **continuity** of care.

•Promotion of **excellence in general practice** and development of capacity in general practice allowing more care to be delivered out of hospital closer to home.

•**Enhanced availability of professional resources**.

•Development of services **within financial constraints.**

The vision will deliver:

•An increase in the number of years CLH patients and residents can live disability free.

•A reduction in health inequalities reducing the difference in life expectancy from best to worst.

•Integrated, well managed and coordinated care at the right time and by doing so maintain the maximum quality of life for our patients for as long as possible.

•Balance budgets offering maximum outcomes for patients within the allocated financial envelope.

6c. CLH Total Indicative Commissioning Budget

The table below details the indicative commissioning budget. Accountability for low complexity budgets has been authorised and delegated to CLH to manage commissioning decisions, budgets and performance as a sub-committee of the PCT Board, supported by the commissioning support resources of the borough, sub-cluster and cluster.

Authorisation processes for medium and high level complexity budgets are currently ongoing.

	DRAFT £
Gross outpatients	16,809,957
QIPP	-1,848,393
net outpatients	14,961,564
Inpatients elective	28,320,000
Inpatients non elective	42,432,000
Urgent care	200,000
A&E	6,144,000
other	1,526,000
Total acute spend	93,583,564
Mental health	36,800,000
Learning disabilities	2,150,000
Physical disabilities	1,650,000
Childrens Services	1,400,000
Older people	6,550,000
Prescribing	12,540,234
IAPT (weighted capitation)	766,647
Community services (weighted capitation)	23,215,605
Other community SLAs (10/11 activity) :	1,094,453
Grand total by cluster	179,750,504
Contingency reserve (0.5% of devolved)	898,753
Grand total by cluster inc. contingency	**180,649,256**

Context

- 7. The case for change
- 8. Quality and safety standards
- 9. Quality, Innovation, Productivity, Prevention plans
- 10. National and regional priorities

7a. The case for change

Do CCGs and Boroughs want to change or add to the case for change? Have the public health priorities changed?

Working with local Directors of Public Health and Borough Directors, CCGs should update the current 2011/12 case for change for (included in appendix 2) based on the Joint Strategic Needs Assessment.

CLH includes neighbourhoods of high deprivation such as Church Street, which is considered as one of the poorest wards in England and has the lowest life expectancy in Westminster. In contrast, adjacent areas such as Bryanston and Dorset Square have some of the highest. The current life expectancy gap between the most deprived and least deprived areas in Westminster is 16.6 years for men and 9.9 years for females.
CLH has an important role to play in closing the life expectancy gap, through targeted, evidence-based, primary prevention interventions; support for those living with long-term conditions, and narrowing the variation in health outcomes. Tackling these issues is more likely to succeed using a 'multi-agency' approach, over a sustained period.
The largest contributors to the life expectancy 'gap' in CLH are cancer, heart disease, stroke, and respiratory illness (with diabetes contributing to a significant number of deaths from cardiovascular disease). Smoking is the single biggest risk factor for CVD and cancer, as well as the single biggest preventable cause of inequalities. Nearly 1 in 4 people in CLH are smokers. Across Westminster, there is high proportion of light smokers (fewer than 10 cigarettes a day) and targeted initiatives should reflect this group. Smoking prevention has long term benefits such as reduced morbidity, hospital admissions, and avoidable premature mortalities.

CLH has lower then (INWL) average numbers of people with at least 1 long term condition (approx 19,620). Of these, 5,232 have co-morbidities (two or more conditions). These co-morbidities are particularly high among the over 65 population. Epidemiological models suggest undiagnosed populations for some conditions including diabetes and COPD. Increasing diagnoses of chronic diseases and the overlaps between them reflect the continued need to focus on improvements in the 'pathways of care'; and ensure there is a 'patient' rather than just a 'disease-focused' approach to service redesign.

Alcohol specific hospital admissions for males and alcohol related crime is significantly high in Westminster compared with England. Alcoholism contributes significantly to years of life lost in under 65s in CLH. Unemployment is a large risk factor for poor mental health. Nearly 1 in 10 working age people are unemployed in CLH. High international migration patterns in CLH make it difficult to implement immunisation and screening programmes.
The Marmot Report demonstrated the critical importance of support for families in the early years. In line with this, commissioning needs to ensure an appropriate mix of universal and proportionately targeted interventions in these early years. There are higher than London average levels of obesity (around 1 in 10 children in reception year, and nearly 30% of Year 6 are obese) and poor oral health in children attending local state schools.

Whilst together with Public Health colleagues we will continue to have a strong focus on prevention, we will also address the reality of an ageing population and the fact that an increasing number of our population will be living with one or more LTC. We will commission and see implemented new models of care, building on the work of the ICP to provide coordinated managed care to patients earlier in their LTC journey, reducing the burden of the disease, allowing them to live well for longer while avoiding interventions later in their journey delivering both patient and economic benefits.

Mental Health Strategies LIT results of Financial Mapping (2009/10) shows that Westminster spends more per person on adult and older people's mental health (£284.6) than any demographically comparable borough, Lambeth (£226). There is a lack of evidence to suggest that this investment is leading to better outcomes and in partnership with the cluster (Inner North West London) CLH seek to develop a whole system approach that ensures quality outcomes, value for money and the delivery of recovery focused, personalised care on behalf of the individuals, families and carers who use these services.

Does the CCG require additional information, analysis, or other support in relation to the case for change?

- Refresh of the provider profiles.
- Inclusion of UCLH in the provider profiles.
- Public Health input needed.

What do CCGs plan to commission in 2012/13 (and to a lesser extent 2013/15) to improve public health that is not covered in subsequent slides?

CLH plan to drive improvements in Mental Health, identifying a robust case for change and developing a long term strategy for our Mental Health services, which includes integrating care.

In line with current NHS strategy and commissioning frameworks, CLH propose that a more significant part of the mental health budget would be better deployed through **a process of realignment** that strengthens primary care based provision and preventative / self management support.

CLH's vision of integrated local care provision seeks to address barriers to the delivery of quality mental health care to users throughout the system by focusing on the redesign of the community and primary care mental health services to deliver improved pathways that are easy to access and integrate more effectively around a full spectrum of individual user needs, including fast access to outpatient or inpatient care where appropriate.

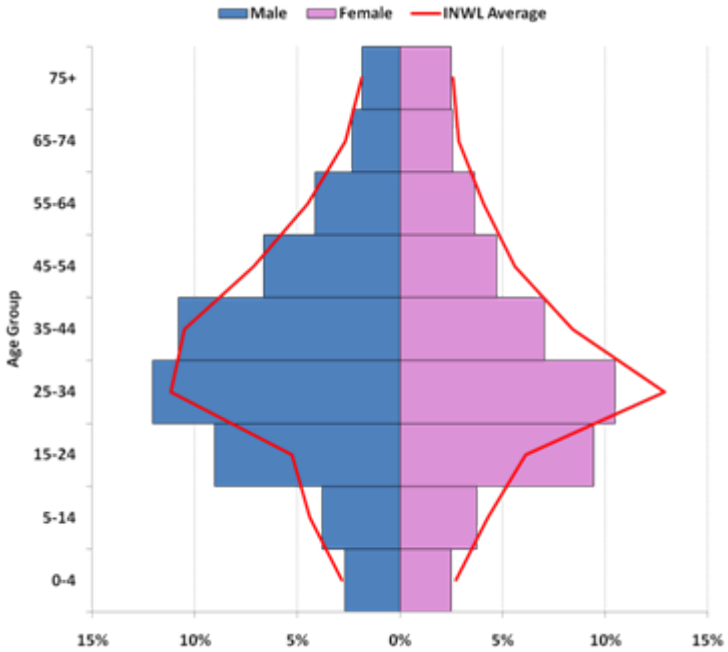
What support do CCGs need to deliver this?

Information tools, data, governance and access to skilled informatics resources are required to realise the core information processes for delivering the strategy.

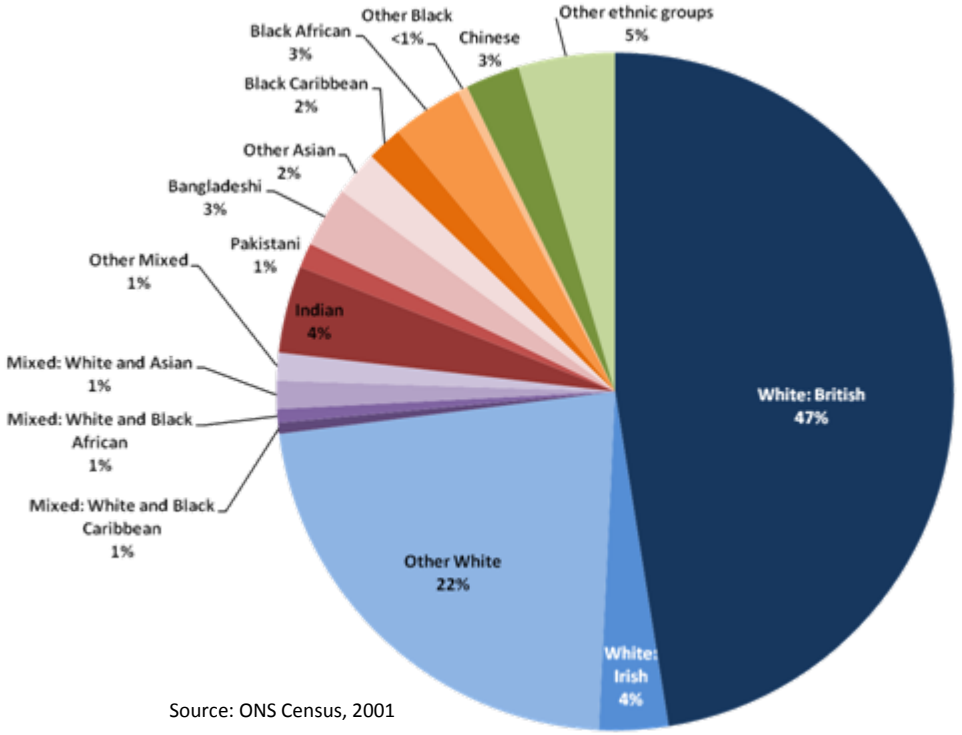
Development of Integrated Commissioning Support and Provision of Service (building on the work of the joint commissioning teams). It is expected the development of this way of working will impact on a number of JSNA areas, in particular that of health inequalities, by the delivery of care pathways and systems of care that both meet the population needs and are easy to access and navigate.

Clinical Commissioning Group Summary – Central London Healthcare

Population Profile



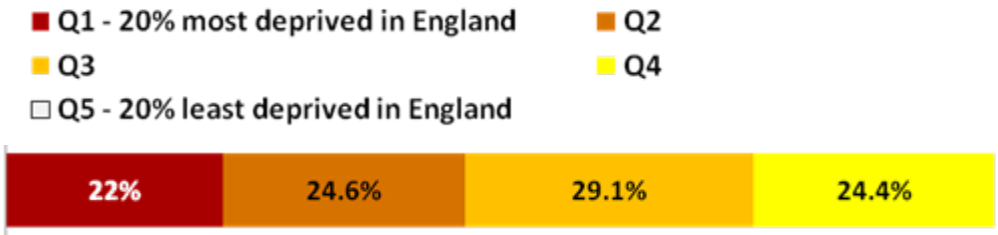
Source: Exeter GP Registrations



Source: ONS Census, 2001

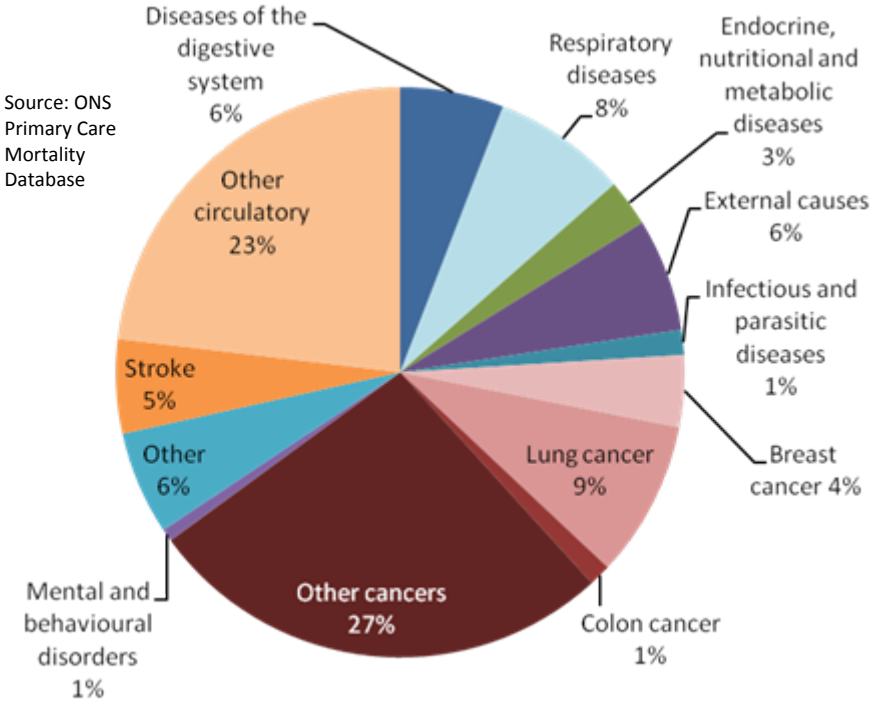
The current CCG registered population stands at 130,800, as of 1st April 2011 (53% male, 47% female). Forty percent of the registered population is aged between 25 and 44 years old, thirteen percent are under 15 years old, and nine percent are aged 65 and over. CLH has more males aged between 15 and 44 years compared to the registered population of INWL CCGs, and fewer females in the age groups covering 25 to 74 years old.

CLH has 27% of its resident population from a black or minority ethnic background (5% Black, 10% Asian, 5% other ethnic groups, 4% mixed). It should be noted that the White ethnicity contains a significant proportion classed as Other White. For CLH patients; analysis by country of birth shows other common countries to be places such as the USA, France, India, Australia and Iraq.



Nearly 55% of CLH patients come from areas in middle quintiles of deprivation. The largest deprivation group for CLH patients is the third most deprived quintile (Q3). There are no patients from the least deprived areas. This is to be expected as there are very few of these areas in INWL.

Major causes of premature (under 75) deaths 2009/10 - 2010/11



Cancer is the major cause of premature deaths in CLH patients, making up 41% of deaths in 2009/10 and 2010/11. Circulatory disease contributes to 28% and respiratory diseases, 8%, respectively.

Major causes of death		
Cancer mortalities	**Circulatory mortalities**	**Respiratory mortalities**
Lung	Coronary heart disease	COPD
Breast	Acute MI	Pneumonia
Prostate	Stroke	
	Heart Failure	

Quality and Outcomes Framework

QOF domain	CCG Prevalence	INWL prevalence	Diff
CHD	**1.9%**	**1.9%**	**0.0%**
Heart Failure	**0.4%**	**0.5%**	**-0.1%**
Diabetes	**2.9%**	**3.3%**	**-0.4%**
COPD	**0.7%**	**1.0%**	**-0.3%**
Cancer	**1.1%**	**1.2%**	**-0.1%**
Atrial Fibrillation	**0.8%**	**0.9%**	**-0.1%**
Asthma	**3.2%**	**3.9%**	**-0.7%**
Mental health	**0.9%**	**1.3%**	**-0.4%**

Source: QMAS data: April 2010- March 2011

CLH has lower than INWL average QOF prevalence for all the clinical domains, apart from CHD where it is the same as the INWL average.

The current 2011/12 case for change for North West London was developed by over 100 senior clinical and managerial and patient representative leaders within North West London. This highlighted the key aims for focus in North West London are:

1	Reducing variation in life expectancy
2	Improving patients' perceptions of our services (especially GP and maternity)
3	Improving care for patients with long term conditions (especially diabetes)
4	Improving primary care (access and outcomes)
5	Improving quality of hospital care (specialisation and decreasing length of stay)
6	Listening and responding to our staff (staff satisfaction)
7	Making better use of our buildings
8	Achieving £1bn of savings

Based on a CCG's local case for change, should we add to or change the NWL case for change?

From feedback from our User Panel and examination of episode statistics, whilst part of 1,2,3 & 4 we would suggest that the Case for Change is changed to explicitly highlight the need for :-

- Earlier intervention addressing conditions that have a significant impact on patients quality of life and wellbeing.
- Systemic change to deliver integrated care which will in turn deliver improved patient outcomes, experience and financial benefits.

The need for a comprehensive strategy with regard to the provider landscape covering:-

- The reduction / reconfiguration of the acute sector (including buildings).
- The transformation of community providers to meet the increased demand on their services.

A similar transformation is required from primary care – this will be undertaken locally by CLH.

8. Quality and safety standards

The Cluster is currently developing a piece of work which aims to produce an evidence based proposal for quality standards across the Cluster to present to the CEC. Are there particular quality standards (NICE, Royal College guidance, CQUINs etc.) that CCGs wish to implement across their area or NWL?

NICE
Management of chronic obstructive pulmonary disease in adults in primary and secondary care
Alcohol-use disorders - preventing harmful drinking
Hypertension: management of hypertension in adults in primary care
Long acting reversible contraception
Postnatal care: Routine postnatal care of women and their babies
Stroke rehabilitation (when finalised)

NHS London – PACE initiative

DH End of Life Care Programme
Gold Standards Framework
Liverpool Care Pathway
Preferred Place of Care

NHS Institute of Innovation and Improvement - Productive General Practice

RCGP - Sustainable Development for GP Commissioners

9a. Quality, Innovation, Productivity and Prevention plans

We will be sending out more detailed guidance about the completion of the QIPP elements of the commissioning strategy, including the financial envelopes shortly and there will be assistance from the Delivery Support Unit which is leading this part of the process. What are the key projects CCGs would like to focus on (rather than the complete detail)?

Transforming primary care

Demand Management
Further development of the Patient Referral Service (PRS) via:-
- C2C all routing via PRS
- Inter-practice referral continued development
- Mental Health referrals routing via PRS
- Timely Information to Practices

Delivering Excellence in General Practice
- Availability / access to general practice (productive practice, pilot access and opening models)
- Improving capacity and capabilities / reducing variations (PRS clinical group, guidelines, coaching)
- Risk stratification - prioritising and identifying and addressing excellent and poor performance.
- Delivery of national targets – CLH is underperforming in relation to certain targets including access to cervical screening and immunisations. The following table provides further detail

Prescribing
Continuing the review and management of prescribing (utilising new QOF elements)
Working with ICH to ensure patients leave hospital with effective drugs that offer value for money

Identification of variation
We will utilise the Pan London General Practice Outcome Standards Performance Framework, PRS data, patient surveys and feedback and other appropriate data sources to identify variations in practice performance, and to monitor the effectiveness of the initiatives above in reducing variation.

Central London Healthcare Underperforming national targets

Level of GP impact	Under performing integrated performance measure		2011/12 annual targets	Month 4/ quarter 1 targets	Latest performance	Period data relates to
			W	W	CLH	
High	Cervical screening	Coverage - 25-49 year olds	70%	70%	66.1%	Month 3
		Coverage - 50-64 year olds	75%	75%	72.9%	Month 3
		Test results received within 2 weeks *	98%	98%	98.9%	Month 3
	Immunisations	Age 1 - 3 doses DTAP/IPV/HiB	95%	95%	90.1%	Quarter 1 (provisional)
		Age 2 - PCV booster	95%	95%	89.0%	Quarter 1 (provisional)
		Age 2 - HiB/MenC booster	95%	95%	90.8%	Quarter 1 (provisional)
		Age 2 - 2 doses MMR	95%	95%	89.0%	Quarter 1 (provisional)
		Age 5 - DTAP/IPV booster	95%	95%	79.5%	Quarter 1 (provisional)
		Age 5 - completed MMR	95%	95%	79.5%	Quarter 1 (provisional)
		Girls aged 12-13 years - HPV all 3 doses *	90%	90%	82.0%	Month 3
	NHS health checks	% people aged 40-74 offered an NHS health check *	21.1%	5.3%	7.0%	Quarter 1
		% people aged 40-74 who have received a health check *	10.5%	2.6%	2.9%	Quarter 1
Medium	Breast screening	Coverage - 53-70 year olds	70%	70%	62.9%	Month 3
	Dental access	Numbers over 24 month period *	119,387	111,291	109,767	Month 4
	Improving access to psychological therapies	% people with depression and/or anxiety disorders who receive psychological therapies *	5.0%	1.1%	1.2%	Quarter 1
		% people referred for psychological therapies who receive psychological therapies *	93.6%	92.2%	56%	Quarter 1
Low	MRSA	No. MRSA bacteraemias *	8	1	2	Month 4
	C.difficile	No. C.difficile cases *	89	28	48	Month 4

* It is not currently possible to report performance to CCG level for this indicator; the data reported as CLH relates to Westminster PCT as a whole

9b. Quality, Innovation, Productivity and Prevention plans

Cont.

Transforming pathways of care:
planned care

Community 'Outpatient' Services
- Enhancement of existing pathways / services (COPD, MSK, Dermatology)
- Monitor other pathways for efficiency, quality and safety
- Inter-practice referrals

Transforming pathways of care:
urgent care
- Access to Primary Care
- Urgent Care Centre @ St Mary's
- 111
- 'Choose Well' and self care
- Paediatric respiratory pathway pilot

Scaling up integrated care Integrated care pilot extension to ONWL, including additional disease groups
Long Term Conditions
- Complex LTC – Integrated Care Pilot Delivery and Expansion
- Less Complex LTC / earlier intervention – 'WellWatch' risk stratified telephone based case management (12/13 saving £0, 13/14 £0.6)

Mental Health – active participation in the ICP and primary care based service implementation.

Cost and value of care Productive community health services
- Development of an appropriate 'currency' – using the falls service as a pilot to examine the use of 'period of care' tariffs to deliver shift of care into the community, integrated service delivery, improved outcomes and efficient use of services .
- Podiatry
- Alcohol Detox

Acute- clinical engagement in claims management processes and quality standards

10. National and regional priorities

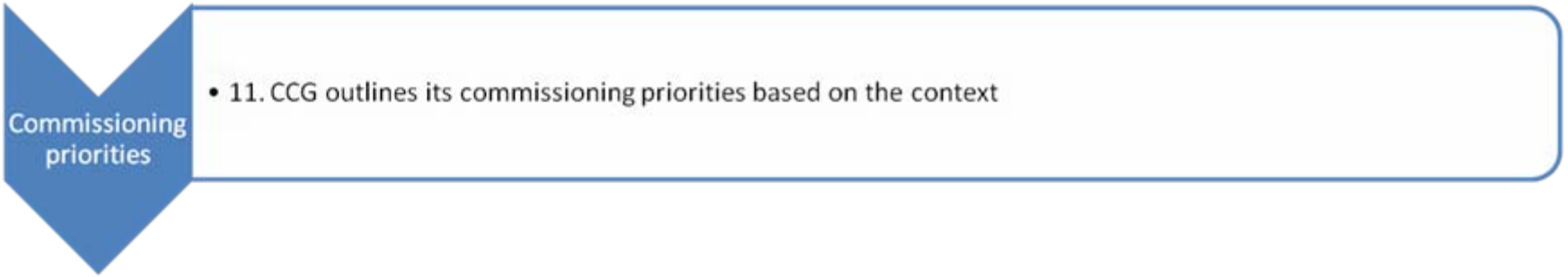
We will share the national and regional priorities as they become known. However, we expect many of the existing priorities to remain, such as commitments to improve Health Visiting, the readmissions pathway, to implement the National Carers and Autism strategies, improving patient choice and information. CCG's should factor national and regional priorities into their commissioning strategy. Is there anything the CCG wishes to emphasise based on local circumstances?

CLH would wish to emphasise the need to extend and develop patient 'Nothing about me without me' to commissioning decisions. The importance of patients working as partners with clinicians to co-design services.

CLH has considerable insight into the needs and preferences of our local population informed by Public Health analysis and major health campaigns together with public feedback, the CLH User Panel and practice Patient Participation Groups and by the primary care clinicians who interact with patients each and every day. This has enabled CLH to identify specific areas of focus which both address these needs and deliver productivity improvements to ensure CLH makes its contribution to reducing the £1 billion gap identified as emerging in NWL by 2014/15.

Areas where shifts in activity, value for money, reducing inequalities and improving clinical outcomes are of particular focus for CLH are:

- Develop the Patient Referral Service
- Non-elective unscheduled care activity
- Mental Health services with specific reference to rough sleepers and substance misusers
- Long Term Conditions redesign of pathways including diabetes and COPD
- Sexual Health services
- Prescribing Indicators
- Planned care including MSK, cardiology, dermatology (maintaining outcomes, while examining efficiencies , minor surgery and gynaecology
- Screening
- End of Life commissioned services
- Health and Well-being in particular homeless families health.



11a. Commissioning priorities

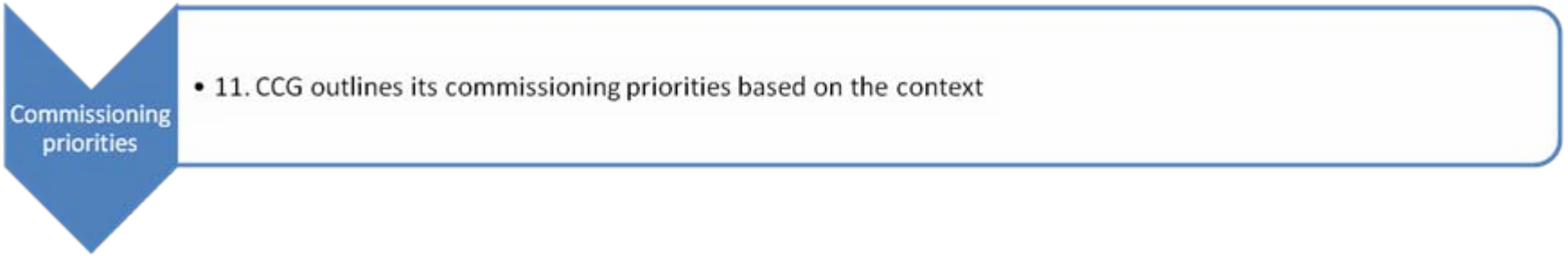
Based on the context above (sections 5 – 10), what are the CCGs commissioning priorities by degree of importance (if helpful, use a scale of 1 to 4 where 1 is low importance)?

✓**Improve Quality**

Reducing inequalities in life expectancy and life without disability (4)
Integrated Care including the development of new currencies (4)
Continuity of Care (Well Watch) (4)
End of Life commissioned services (3)
Giving frontline CLH professionals more influence and a stronger leadership role (3)

✓**Ensure Innovation**

Develop the Patient Referral Service (4)
Planned care including MSK, dermatology, minor surgery and gynaecology (4)
Develop the innovative sharing of data between primary and community providers via the CQUIN mechanism to promote better multidisciplinary working and the UCT IT Project(3)



11b. Commissioning priorities cont.

Based on the context above (sections 5 – 10), what are the CCGs commissioning priorities by degree of importance (if helpful, use a scale of 1 to 4 where 1 is low importance)?

✓**Improve Productivity**
Case Management and Care Coordination for those with LTCs earlier in their journey (4)
Non-elective unscheduled care activity (4)
Improve the efficiency of the local community health providers through better collaboration with secondary care provision to reduce delayed discharges and length of stays, as well as promoting and supporting self management and reduction in non elective admissions (3)
Managed productivity savings (acute sector landscape) from secondary care (3)
Productivity savings from Community Providers (in advance of longer term investments in transformed effective community services and redesign of community services to ensure they can support care closer to home (3)
Through the Patient Referral Service and improved community triage, reduce referral to inappropriate outpatient and secondary care appointments (3)
Maximising investment in demand management and community 'out patient' pathways (3)
Review the Patient Referral Service in Central London Healthcare to see if our other CCGs can benefit from its achievements. (2)
Improved integrated mental health pathways (4)

✓**Support Prevention**
Community Mental Health (4)
Improve uptake of screening services and immunisations (3)
Health and Well-being in particular homeless families health (3)
Giving patients more power and choice (3)

✓**Olympics**
Commission services and work with providers of currently commissioned services to ensure appropriate services with appropriate capacity are in place for the Olympics (3)

12a. Commissioning strategy - acute

•What is the current financial and operational performance for the main acute providers the CCGs will commission from?

- •How much is spent on each provider
- •What key operational priorities (quality, access etc.) do providers meet and not meet?

Based on the case for change and current performance, what is the CCG's **strategy** for commissioning acute provision?

The main NHS Westminster SLAs with acute providers are detailed below;

Imperial College, £87,492,881;
Chelsea and Westminster, £22,627,368;
UCLH, £22,456,970 (tbc); and
Guy's and St Thomas' £11,922,397.

Work is currently underway to accurately break these budgets down to CCG and practice level, presently this is difficult within Westminster due to the number of CCGs and excluded practices. The above information gives a sense of scale in terms of the overall borough budgets, historically CLH counts for c. 55% (using outpatients outturn for 10/11).

Detail of key operational performance issues are being compiled in discussions with the ACV and will be addressed as part of the 2012/13 SLA round.

12b. Commissioning strategy - acute

•What is the current financial and operational performance for the main acute providers the CCGs will commission from?
- •How much is spent on each provider
- •What key operational priorities (quality, access etc.) do providers meet and not meet?

Based on the case for change and current performance, what is the CCG's **strategy** for commissioning acute provision?

The CLH commissioning strategy is based on generic themes around:

•Shifting activity into the community setting / primary care to achieve improved patient pathways, high quality services and efficiency savings. Areas of focus include ophthalmology, gynaecology, muscular-skeletal services and minor surgery procedures.
•The utilisation data driven intelligence tracking live patient data
•Payment in line with SUS with active clinical participation in the validation and claims management processes for acute services
•To ensure access to services within maximum waiting times under the NHS Constitution will continue
•Greater control over activity in particular C2C referrals
•Focusing on healthcare outcomes and quality standards e.g. via CQUIN route and close scrutiny of provider quality accounts
•Commissioning for improved efficiency including reduced LOS / higher DC rates / reduced readmissions / benchmarking
•Assess ITU admission and discharge criteria
•Being active in the development and negotiation of contracts with providers and use the opportunities of developments of the tariff to Secure value and more responsive and integrated services
•Viable plans for transition, agreed strategy of the landscape and ensuring a viable acute landscape
•Separation of secondary and specialist (as per UCLH – learning)
•Partnership forums
•Maximising opportunities for shared risk reward

If known, what implications does the strategy have on what and how CCGs specifically plan to commission in 2012/13 (and to a lesser extent 2013/15)?

- Transformation of Community Services
- A consolidation of some services and localisation into the community of others will mean the movement of income and services between providers
- Non-acute providers will need to be more productive and efficient, so that they can either contain activity at current levels and cost or provide additional activity (excluding demographic growth) at current price levels.
- Reducing capacity plans in the acute sector and re-providing it in the community via demand management schemes. There will need to be market testing and procurement exercises undertaken
- Greater involvement in the development of CQUINS and monitoring quality performance
- Commissioning for outcomes
- Payment based on SUS
- Management of C2C referrals via the CLH Patient Referral Service
- De-commissioning of acute activity in relevant areas of demand management
- Staff may need to work differently in the future, especially working more closely with colleagues in different care settings, providing more outreach services and support in the community
- Some Trusts may struggle to respond to efficiency pressures impacting on financial or clinical viability and will need to look at options such as merging/collaborating with other organisations and/or putting in place network support arrangements with other Trusts.
- Providers of out-of-hospital services will need to work together to provide out of hospital care more efficiently and reduce demand for activity through joint working.
- Clinicians working across professional boundaries / care settings.

What support do CCGs need to deliver this?

Information tools, governance, data and capabilities: information tools, data, governance and capabilities are required to realise the core information processes for delivering the strategy.

CLH will require procurement expertise to carry out market testing in relevant key areas and benchmark services and undertake full procurement exercises.

13a. Commissioning strategy – community health

What is the current financial and operational performance for the main community providers the CCGs will commission from?

2011/12 Contract value for CLH - £ 23,215,805

Key Performance issues:
Community nursing – face to face contact low
Extended waiting times in some services
Health Visiting – Low contact rates and high DNA rates for child development checks
Podiatry
Services supporting hospital avoidance – e.g. diabetes follow-up, respiratory and urgent care
Data
Rebasing of contract
Risk Stratification operated by main provider focused on a population needs basis rather than individual patient presentation.

Based on the case for change and current performance, what is the CCG's **strategy** for commissioning community health provision?

Short term 12/13

- Rebasing the 2012/13 contract
- Additional investment – delivery / ROI
- Improve productivity and patient facing time
- Aim to negotiate a 5% reduction in contract value with main community provider to achieve an efficiency saving
- Ensure that service specifications and contract are outcome focussed – i.e. linked to delivery of key QIPP targets with penalties and incentives
- Undertake benchmarking of services to ensure best value & efficiency
- Review community nursing and podiatry to ensure value for money
- Develop Any Qualified Provider for certain services - MSK & podiatry
- Respiratory – move more outpatient activity, particularly follow-up into the community/ primary care
- Diabetes – there remains scope for more follow up attendances to move into the community service
- Urgent care – review current service/ pathway to reduce subsequent hospital attendance/ admission
- Roll out shadow falls tariff with view of commissioning service in future on cost & volume basis
- Implementing the new Falls Service Model within Westminster
- To use risk stratification tools at practice level in order to ensure patients in need receive services on a whole population basis.
- Closer working with the Local Authority

13a. Commissioning strategy – community health (cont)

Mid term

- New currencies – integration and a move to payment on outcomes (inc community tariffs)
- Increased investment (but net saving compared to Acute)
- Increased capacity to ensure the community provision serves the whole population allowing the decommissioning of acute provision.
- Any qualified provider – where market exists (analysis needed)
- Integration of provision with social care
- Maximising the impact of the capacity and capabilities of the Voluntary sector through AQP and other means.
- Line by line analysis of funding to providers (inc social care) to ensure services are delivering outcomes for patients and value for money.

13b. Commissioning strategy – community health

Based on the case for change and current performance, what is the CCG's **strategy** for commissioning community health provision? Continued

In promoting greater patient choice and control, subject to affordability and quality considerations, the CCG will consider the use of Any Qualified Provider to enable greater participation by social enterprises to provide services, alongside other providers, to deliver community services.

CLH will undertake market testing in relevant key areas and benchmark services.

CLH will ensure value for money and high quality services and commission for outcomes

Improved information and using data intelligence including live time patient tracking in service utilisation

To ensure effective health visiting services, with sufficient capacity to deliver the new service model to be set out in the *Health Visitor Implementation Plan 2011-2015 – A Call to Action*, to deliver the Healthy Child Programme, provide greater support to families and develop local community capacity in support of children and families, working closely with Sure Start Children's Centres and other local services

To assess the needs of people with autism and then plan and commission services as appropriate to address those needs.

Implementation of the National Dementia Strategy 2010 four priority areas

New currencies – integration

Joint working with the Local Authority

If known, what implications does the strategy have on what and how CCGs specifically plan to commission in 2012/13 (and to a lesser extent 2013/15)?

Market Testing for services e.g. Muscular-skeletal services 12/13 and community minor surgery 12/13
Outcome framework to be part of contract to link to QIPP delivery targets – penalties and incentives
Reduced routine “non core” podiatry
Review health visiting, rehabilitation and district nursing
Decommissioning of continuing care nursing homes and re-commissioning
Review community services where also provided in acute, particularly where no benefit in terms of costs

What support do CCGs need to deliver this?

CLH require a strong contractual function that will maximise contract levers, deliver outcomes and ensure high quality and safe value for money services from all providers.

Accurate and timely financial and activity data.

Procurement expertise.

14. Commissioning strategy – mental health

What is the current financial and operational performance for the main mental health providers the CCGs will commission from?

The main provider is CNWL who provide core statutory inpatient and community services for people with a severe mental illness (SMI). Primary care psychology services (IAPT) for people with a mild to moderate illness are provided by CLCH. WLMHT provide forensic services. WLMHT and CNWL services include rehabilitation services. The other high spend area of the budget is placements, which are offered by a range of independent providers.

Key performance issues are:

CNWL achieved a successful delivery of CQUIN targets last year and met their crisis resolution and early intervention team targets. They achieved £600k in savings for the PCT in 2010/11 by returning people from out of borough to local services. They are being proactive in piloting a ward closure and recently won a tender to provide a Primary Care Liaison service in Kensington and Chelsea. An enhanced model of primary care mental health provision is in the advanced stages of implementation.

However:

- National data shows patient experience in inpatient services to be below average for CNWL and average for the community.
- Admissions rates are high and lengths of stay long when benchmarked against similar areas.
- CNWL's own analysis shows that the service is very over-bedded when benchmarked.
- Length of stay in forensic is beginning to reduce as a result of investment in community forensic teams but whether this is bringing a net saving is yet to be evaluated.
- The IAPT service does not take self referrals in line with guidance, the proportion of those diagnosed receiving and proportion of those referred receiving services needs improvement. Waiting times are an ongoing concern. Referral pathways with LTC services e.g. diabetes, in early stages of development.
- Financial benchmarking shows significantly more cost per head in certain spend areas than London or the other INWL PCTs – especially CMHTs and accommodation services. This information is being drilled down to improve understanding of this variation.

Based on the case for change and current performance, what is the CCG's strategy for commissioning mental health provision?

The strategy must improve quality and value for money. This needs to be done jointly with the Local Authority who deliver integrated services with the Trust and provide supported accommodation and independent housing. In mental health services the strategic objectives will be as follows:

•Support a recovery ethos in mental health services which significantly improves patient experience and ensures that people with a mental illness are supported to live as independent a life as possible while recognising that mental illness is a long term and potentially relapsing condition. Within this:
- Improve choice by preparing for payment by results and developing meaningful information to inform patients' choices about treatment provider.
- Improve the quality of care on the wards to reduce inappropriate lengths of stay to allow a reduction in inpatient beds.
- Support developments which enable more patients to be supported in primary care.
- We will ensure that we commission rehabilitation pathways rather than individual services to improve rates of move on to more independent living.
- Ensure that services are designed in a way that addresses the holistic needs of individuals in a way that promotes well being and prevents the deterioration or relapses in SMI. This will include considering and addressing other needs such as substance misuse as well as the wider determinants of mental well-being such as meaningful employment and strong social networks.
-Ensure that services for people with a mild –moderate illness are effective and appropriately targeted in line with agreed priority groups.
•Develop the integrated care model to include mental health, focussing on people with long term conditions, improved care for people in acute hospitals and shifting settings of care across the primary to secondary care continuum.

If known, what implications does the strategy have on what and how CCGs specifically plan to commission in 2012/13 (and to a lesser extent 2013/15)?

To ensure that the above strategic objectives are met we will:

•Develop an enhanced model of primary care provision for mental health. This model will include:

•A single point of access for mental health patients to ensure consistency and appropriate referrals.

• More people with more complex mental health needs and additional needs (such as substance misuse), are supported in primary care settings, thereby improving patient experience and improving the quality of their physical healthcare.

•Ensuring that the provision of primary care psychologies is NICE compliant and value for money and provides patients with choice.

•Additionally, we will:

- •Work with the ICP and with other CCGs as part of the development of the model.
- •In line with London Health Programmes recommendations, evaluate the local Navigator provision in Kensington and Chelsea and look to engage with the voluntary sector to deliver provision if effective.
- •Evaluate effectiveness of Early Intervention provision and implement an optimal outreach model within primary care settings.
- •Learn from tier 1 and 2 Personality Disorder Service evaluation to consider if effective.
- •Implement 111.

•Building on the development of local recovery teams, support the Implementation of Recovery in Organisational Change programme in CNWL (evidence-based programme promoted by the Centre for Mental Health), including the establishment of a recovery college and peer support workers. Embed performance measures for the effectiveness of this programme in contract monitoring.

•Agree actions with CNWL to improve alternatives to admission and quality of care on the wards to reduce length of stay and within this:

- •Agree feasibility of bed closures and associated savings.
- •Review outcomes of pilot project for individuals with a personality disorder who are admitted (St Charles and Gordon Hospital) and take steps to reduce admissions and length of stay for these individuals (N.B. CNWL estimated that £2.7m per year is spent on this client group by Kensington and Chelsea and Westminster.).

- Agree a CQUIN relating to addressing substance misuse needs of inpatients and clients in the community.
- Continue to proactively support the Trust to manage delayed discharges with local authority partners.

- Commission a three PCT court diversion scheme for people with mental health needs.
- Evaluate the FOCUS team to determine if investment is returning savings.
- Work with specialist commissioning to improve quality of care and step down rates from forensic.
- Re-specify and commission rehabilitation provision as a pathway, including the requirement for providers to give time limits on required length of treatment.
- Work with the Local Authority and voluntary sector to ensure these pathways are complemented by services that promote meaningful activity and social inclusion on a long-term basis, including supporting the Local Authority day services reconfiguration as part of its savings' programmes.
- Agree an employment CQUIN with CNWL.

What support do CCGs need to deliver this?

Clarity and understanding of the investment in Mental Health services on a line by line service by service basis including VFM compared to other areas in NWL and across the country.
Information about activity and outcomes.
Access to contractual expertise.
Access to specialist Mental Health commissioning expertise in particular for the commissioning of non community based Mental Health services.
Support to move to PBR / outcomes based currencies.

15. Commissioning strategy – jointly commissioned services

What is the current performance in relation to jointly commissioned services that CCGs will commission?

The following services are jointly commissioned with Westminster City Council through a S75 Commissioning Agreement and, where appropriate S256 memoranda:

•Services for older people and younger adults with physical disabilities including equipment, placements, rehabilitation and intermediate care, information and advice and advocacy.
•Services for people with learning disabilities including day care, respite care, placements and access to health services.
•Services for carers, including respite care and the development of personal budgets.
•Services for substance misuse, including prevention, treatment and care .
•Public health initiatives, particularly relating to prevention and housing issues.
•Services for mental health (see previous section) including Safeguarding.

Key performance issues:
A lack of measurement of outcomes achieved for patients as contracts primarily based on resources deployed (inputs).

Based on the case for change and current performance, what is the CCG's **strategy** for commissioning jointly commissioned services?

To deliver the QIPP agenda and deliver care closer to home integrated commissioning must become the default:-

- CLH is committed to the development of integrated pathways of care across health and social care, shifting care from acute to community and primary care settings, reducing hospital admissions and improving early discharge.
- The development of an integrated commissioning resource across the Tri-borough area will be an important step in securing integrated provision both from our major providers (Central London Community Healthcare will be merging with social care services) and from the wide range of alternative community providers working in the borough to provide services for vulnerable adults.
- CLH will be full partners in the development of specifications for integrated services, building on the experience of the Integrated Care Pilot and other joint work, and on the already established integrated care provided in mental health and learning disabilities.
- An integrated approach to the delivery of intermediate care and rehabilitation will be key in reducing unnecessary admissions to hospital and to residential and nursing home care, as well as facilitating prompt and effective discharge, providing better care for people and minimising their stay in hospital.
- CLH will commission jointly with WCC support for patients such as advice, information and advocacy and community based support to maintain their health and wellbeing.
- CLH will commission jointly with WCC support for carers such as advice, information and respite care to enable them to sustain their caring role.
- CLH will commission jointly with WCC support for older people in the community to maintain their health and wellbeing and prevention social isolation and deterioration.
- CLH will commission jointly with WCC services for people with learning disabilities, ensuring that access to healthcare is maintained and improved in line with best practice.
- CLH will work with WCC to deliver the National Dementia Strategy 2010 four priority areas.

If known, what implications does the strategy have on what and how CCGs specifically plan to commission in 2012/13 (and to a lesser extent 2013/15)?

Key QIPP Priorities for 2012-13 are:

Quality	Secure responsive and effective community based risk stratification, care planning and delivery from community nursing Implement the GSF for End of Life Care across the borough Increase the level and quality of access to health care for people with learning disabilities Implementation of the National Dementia Strategy 2010 four priority areas
Innovation	Integrate pathways for rehabilitation and intermediate care Implement personal budgets for carers
Productivity	Secure CLCH financial and pathway efficiencies across INWL PCTs for community nursing and therapies Increase the cost effectiveness of long term care placements across all care groups through, for example, the use of the Care Funding Calculator or other benchmarking tool Development of shadow community tariffs initially for falls
Prevention	Implement more effective fall services Establish risk stratification model and early intervention to prevent admissions to hospital or A&E attendances for people with long term conditions Improve quality and scope of continence services to prevent unnecessary admissions to hospital or residential care

What support do CCGs need to deliver this?
Support to address the following :-

- Infrastructure issues such as IT which inhibit integration
- Lack of evidence of the impact of social care interventions which could lead to effective interventions being decommissioned or not implemented
- Lack of whole systems health-economics approach which could lead to reduced investment in one part of the system leading to increased costs elsewhere and an overall increase in costs to the public purse
- No systemically applied method to measure 'wellbeing'.

16. Commissioning strategy – integrated and out of hospital care

What is the current performance in relation to integrated and out of hospital care that CCGs will commission?

- Admissions to care homes high when compared to other boroughs
- Health services delivered in parallel rather than jointly, with social care services
- Emergency admissions are not decreasing

Based on the case for change and current performance, what is the CCG's **strategy** for commissioning integrated and out of hospital care?

- The CCG is fully committed to personal budgets which will allow greater integration between health and social care at the level of the individual and give them more choice and control over their care.

- Key priority to transfer activity into the most appropriate setting and will review services and go to the market for alternative providers if business cases evidence a strong financial and quality case.

- To work towards achieving the vision of the End of Life Care Strategy and commission the care people want, coordinating care across sectors.

- Improve outcomes for people with stroke and to continue supporting the out of hospital stroke support service in order to reduce length of stay and enable more people to be rehabilitated at home.

- To support the integration of NHS intermediate care and Local Authority re-ablement services.

- To support the integration of health and social care services for people with long term conditions.

- To support and expand the ICP programme.

- Support the implementation of the Health Visiting strategy with local authorities in children's centres

- Working on developing the integration of children's care pathways across providers to reduce duplication and improve quality, whilst reducing the pressure on hospital activity.
- Joint working with the Local Authority

If known, what implications does the strategy have on what and how CCGs specifically plan to commission in 2012/13 (and to a lesser extent 2013/15)?

- Commission a joint intermediate care and re-ablement service with a single point of access, single assessment process, shared working protocols, single management structure and working within a joint performance framework, which will be outcome focussed
- Commission a joint health and social care service which will focus on the patient and their pathway of care and will be outcome focussed
- Expected to reduce emergency admissions, reduce hospital length of stay and reduce the number of admissions to residential or nursing home care
- Development and implementation of new currencies to encourage integration, shift of care and the delivery of outcomes for example, the period of care tariffs proposed for End of Life Care and Mental Health.

What support do CCGs need to deliver this?

See previous sections.

17. Commissioning strategy – other

How would the CCG wish to influence the strategy for NHS CB-commissioned services, including specialised commissioning, pan-London, prison and military health services?

CLH would like to see an improved interface between services to address the multiple and complex nature of prisoners including mental health issues, substance misuse and infectious diseases.

CLH would like to see robust financial and performance activity from specialised services and clarity regarding risk share agreements.

How would the CCG wish to influence the primary care strategy, including dental, pharmacy and optometry services?

CLH is fully committed to improving access to NHS Dentistry and promoting improvements in oral health, especially in children. Locally there is a higher than average level of poor oral health in children attending state schools.

CLH wish to maintain and develop pharmaceutical services, including local enhanced services to meet pharmaceutical needs and optimise the use of medicines especially in people with long term conditions.

CLH wish to look a pathways which would allow more patients who are entitled to free prescriptions to obtain their 'over the counter' medicines without visiting a GP where it is safe for them to do so.

CLH would like to work with pharmacists to see how their services and ways of working can add capacity to the systems and support patients to choose well.

CLH would wish to work with optometrists to redesign the pathways to reduce referrals to secondary care which can be dealt with in primary care.

In the development of the strategy for commissioning general practice in particular, is there anything CCGs want to contribute?

Increasing capacity and expanding services in general practice will be key to the shift of care from the acute sector and the delivery of the QIPP plan, CLH would wish to see the strategy for commissioning general practice encourage innovation and joint working between practices.

Working together with Primary Care commissioners to deliver excellence in general practice.

18. Service configuration

List the existing service reconfigurations that the CCG is responding to

As outlined in London's Strategic Planning Principles 12/13 & 14/15, CLH will consider work completed or under way by the pan-London care pathway clinical working groups, including service reviews, as well as national and London-wide priorities in the following areas:

- Cardiovascular services
- Cancer services
- Mental health
- Acute Medicine and Emergency General Surgery
- End of Life Care
- Tertiary paediatrics
- Maternity services
- Public health and prevention

Locally there are configurations that CLH is engaged in including the following:

- Orthopaedic Pathway
- Vascular Pathway
- The Crescent Cancer Services
- Urgent Care / A&E
- Regional Trauma Networks

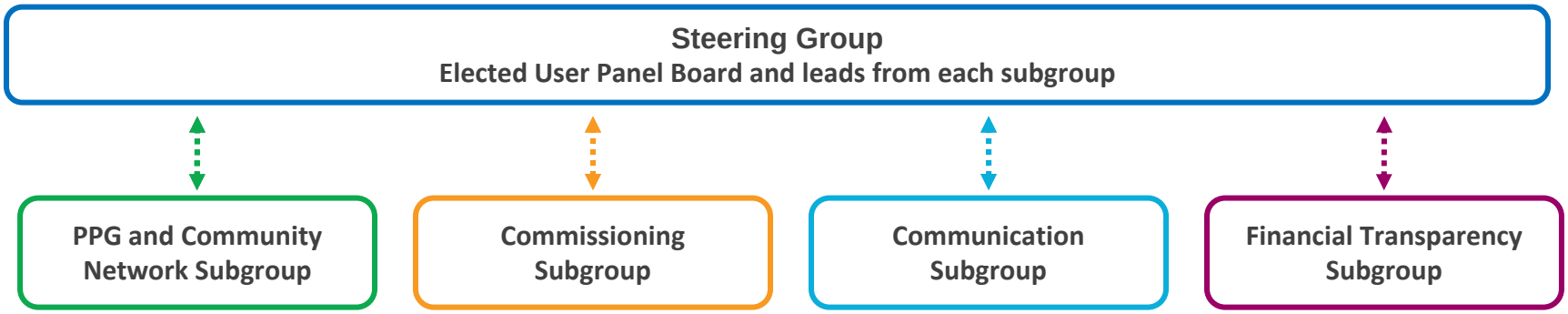
Are there any additional service configuration changes that the CCG would wish to see?

- Working with NWL and Acute providers to develop a provider landscape that is fit for the future.

19. Patient and Public engagement

How is the CCG working with patients, the public and organisations that represent them in the development of the CCG's commissioning strategy?

- CLH have an active User Panel consisting of approximately 20 patients from Patient Participation Groups across our GP practices.
- The elected User Panel Chair has been a full voting member of the Board for three years.
- The User Panel members are involved with all CLH undertakings supported by CLH management team. The User Panel work-streams currently include:
  - Patient and public engagement strategy
  - PPG and community network development
  - Transparency and accountability tools
  - Patient communication materials
  - Older persons befriending pilot
  - Service redesign
- To support their ability to effectively tackle different projects, the User Panel operates in small subgroups:



- CLH maintains links with various groups which represent particular patients or groups within our population, such as BME Health Forum and senior citizen groups
- We are developing a close relationship with HealthWatch (LINks) to ensure the two groups work together effectively, with a User Panel member attending HealthWatch meetings and a HealthWatch CLH patient has been invited to join the User Panel
- It should be noted that the National Association for Patient Participation has identified CLH as a leader in regards to a CCG driven patient engagement model
- We will be working with INWL next year to develop wider public consultation approaches
- We have been working with INWL to develop wider public consultation approaches through LINks and other user forums.

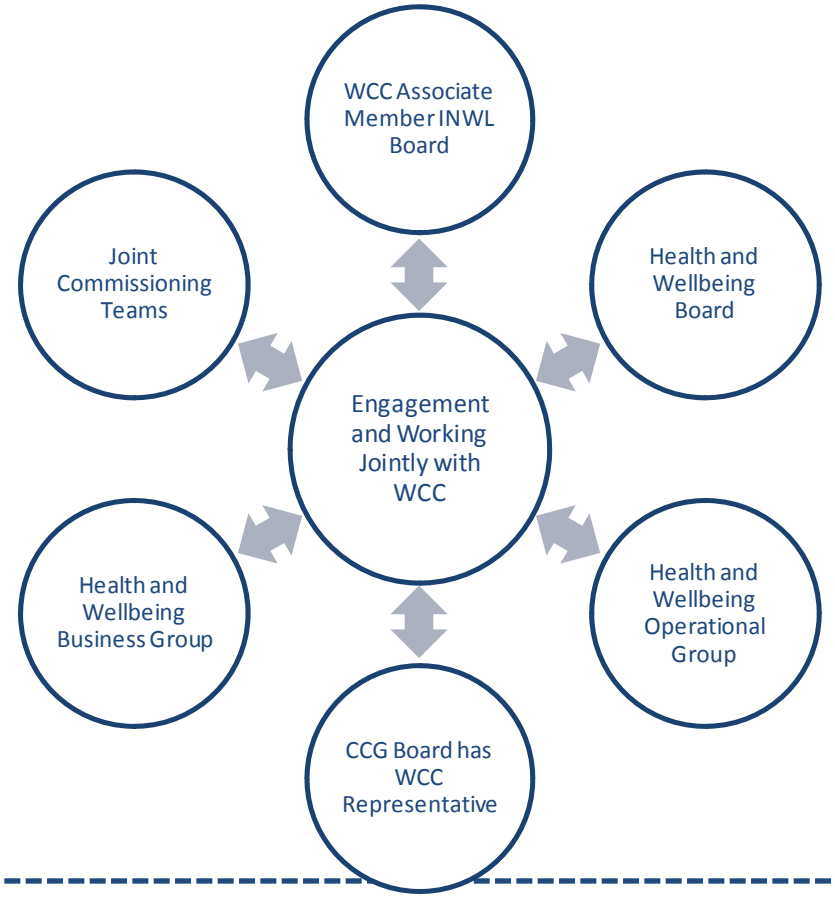
20. Shadow Health and Wellbeing Board engagement

How is the CCG working with local shadow Health and Wellbeing Boards in the development of the CCG's commissioning strategy?

Westminster City Council has established a H&WBB, which will operate at two levels:

1. A Strategic Board meets quarterly, the Chair of CLH will be a member of this Board.
2. An operational board which meets monthly the MD of CLH is a member of this board.

CLH together with Victoria Commissioning Consortia and the Borough team are submitting proposals that will form the work plan of the H&WBB. The diagram below reflects the cohesive approach that VCC' INWL's Westminster Borough team; Westminster City Council and the Tri-Borough Partnership are taking to work together.



21. Beyond 2012/13

Does the CCG have any strategic intent at this stage beyond the next financial year in relation to either the commissioning of health services or the changes in the health landscape?

The scope for productivity saving beyond 12/13 will be challenging without systemic change, CLH see it as essential that the vast majority of our efforts and those of our commissioning support colleagues focus on these longer term changes which will take time to implement and to deliver outcomes for patients and economic benefits. Key priorities are :-

- Acute sector landscape and a plan to get to the end point while ensuring continuity of services.
- Transformation of community services, moving to period of care tariff, introduction of any qualified provider where appropriate, increasing capability and capacity.
- Development of Primary Care.
- Active support of Integrated Care Pathways.
- Joint working with the Local Authority.
- Review of the provision of Mental Health services.
- Specific projects to be implemented in 12/13 that will deliver benefits beyond 12/13:
    - Well Watch (case management, earlier intervention)
    - Community Mental Health.

22. Presentation to Clinical Executive Committee

By way of summary...

Central London Healthcare CCG has robust plans to meet the QIPP challenge and develop clinician and user led commissioning up to and including 2014/15.

CLH intends to deliver the required quantum shift both in commissioning and in delivery of services by effective collaborative work between general practices, other community based and Acute services, the Local Authority, Voluntary Sector and Service Users in order to provide high quality care within a constrained financial envelope. CLH recognises the importance of localisation in commissioning and in service delivery as well as the needs of the wider Health and Social Care Economy.

CLH intends to

- Move care of those patients which does do not have to be delivered by hospital based specialist services (estimated as high as 30% of current total) away from the Acute Sector and into high quality, highly productive services based in the Community including general practice. Such services will be provided at lower cost and in a more appropriate and convenient setting for patients.
-Develop general practices to ensure consistency in delivery, highest achievable quality and equity in access for all users of services in both the registered and non registered populations.
-Work with other Community based providers to ensure services are delivered in a population based manner, focussed on need and recovery, ensuring high quality and productivity in those services.
-Use CLH's existing Patient Referral Service to triage referrals from primary, other community and specialist providers to ensure:

- optimal use of the wide range of services on offer
- adherence to best practice guidelines for referrals
- identification of gaps in services
- support for claims management
- provision of active feedback from peers driving consistency and quality in clinical practice
- providing a one stop service to patients to access services
- reduction in DNA rates

All these aspects of the PRS have already been demonstrated in the last 18 months of full operation.

22. Presentation to Clinical Executive Committee cont.

-Use CLH's existing risk stratification tool ('Wellwatch') for all patients aged over 18years to target services where they will have most impact on patients health and wellbeing, reducing inequality and adopting a whole population approach.

-Ensure integration with other health and social care providers maximising efficiency and effectiveness of patient care when transferring between providers, reducing unplanned hospital admissions and aligning incentives between providers within the local Health and Socialcare Economy.

-Ensure integration of our commissioning of healthcare with the commissioning carried out by Local Authority and Public Health with special regard to the JSNA and joint work with Health and Wellbeing Boards (currently underway with Westminster Shadow HWBB).

- Design innovative, service user focussed mental health services based where clinically appropriate in primary care and the community providing:

- a whole person approach
- integration of physical and mental healthcare especially with regard to long term medical conditions
- integration of mental health services with those targeted at substance misuse including alcohol
- improvement in equity of access and removal of stigmatisation associated with such access
- recognition the effect mental health and substance misuse on all aspects of healthcare, on social wellbeing and on employment.

-Ensure throughout all service redesign and commission decision making there is a continuation and development of truly collaborative working with our users.

-Ensure probity and manage conflict of interest through financial transparency and joint work with Service Users and other stakeholders. The CLH Financial Transparency sub group is already established with regular meetings. The core group currently comprises 3 patients registered with CLH practices with expertise in financial management and the clinical Chair.

-Work with other groups of commissioners including other CCGs to ensure the most cost effective use of commissioning resources and equity of service provision for users, balancing the need for localised engagement in and commitment to commissioning decision making and service delivery with needs of the wider Health and Social Care Economy.