Croydon Clinical Commissioning Group

Attachment 06

Appendix 1

NHS Croydon Clinical Commissioning Group

Commissioning Intentions

2013/14

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1. Introduction

The purpose of the commissioning intentions is to describe to our Providers how the integrated Strategic Operating Plan will impact on their services.

1.1. Vision and Strategic Goals

NHS Croydon Clinical Commissioning Group vision is

Longer, healthier lives for all the people in Croydon

NHS Croydon Clinical Commissioning Group faces significant challenges including an ageing population, rising demand for services and high public expectations of those services.

In addition to this Croydon Clinical Commissioning Group also faces significant financial challenges during 2013/14 and in future years with the consequence that funding will not be able to match the increasing demand for NHS services.
.
Croydon CCG will commission health services for its population, based on current performance, 2012/13 Operating Plan financial targets (e.g. 1% surplus), and the current definition of CCG commissioning responsibilities.

In response to the change in our commissioning responsibilities, our Community Health Services Provider will have services commissioned by Croydon Clinical Commissioning Group and Croydon Local Authority Commissioning and Public Health.

The recommended financial strategy is to deliver £20m savings over each of the following three years (2013/14 – 2015/16) to deliver a balanced position against the downside scenario by end of 2015/16. This recognises the time it will take to recover the position and delivers a risk buffer in the base case scenario. This would largely deliver statutory balance in 2013/14, and full recovery by 2015.

London Borough of Croydon is also expected to manage a funding reduction of 26% over a four year period.

To meet the 3 main challenges, our demography, high public expectations and financial constraints, Croydon Clinical Commissioning Group will be commissioning Provider services in very different ways.

Through the development of robust integrated care pathways and in line with the jointly owned transformation agenda, the provider landscape will see more services move from the acute setting into intermediate, community home care settings and primary care.
Our service functions for each of our locality networks will be matched against the local health needs and drawn together in an integrated approach to service delivery. Services where

appropriate will be housed together to achieve better integration to facilitate the delivery of care pathways.

Where possible we will use a one stop shop approach to meet our populations health needs and to direct people to the most appropriate point of service entry. Over time, using the health portrait as a benchmark we will measure the changing patterns of health and wellbeing in each locality network. Services will be adjusted and where necessary re commissioned to achieve improved health outcomes and value for money.

A key overarching theme throughout our commissioning intentions is that people will be seen in the 'right place' at the 'right time' with as few steps in their pathway as appropriate to deliver high quality care and better use of resources.

1.2. Our Priorities

Through our involvement with developing the Health and Wellbeing Strategy and working with our stakeholders we have identified 8 strategic priorities.

Our main focus in delivering our priorities is that there is an emphasis on the prevention of ill health and supporting people to manage their conditions well. We will ensure that through the development of integrated pathways, that people are seen in the 'right place' at the 'right time.'

This section describes how throughout 2012/13 we have been tackling these priority areas and how we intend to tackle the priorities throughout 2013/14, including how we are aligned with the Public Health and Local Authority commissioning in each of the following areas.

- Prevention of Ill Health
- Self-Management
- Long Term Conditions including Mental Health / End of Life Care / Continuing Healthcare
- Maternity and New Borns
- Children and Young People
- Planned Care
- Primary Care
- Urgent Care

1.3. Priority initiatives and the strategic direction of travel:

- Prevention of Ill Health - communities and individuals will be more involved and active participants in improving their own health.
- Self-Management - there will more people managing their conditions well.
- Planned Care – and through robust care pathways more people will receive their care closer to home than in a hospital setting.
- Long Term Conditions – we will have integrated care pathways for people with Long Term conditions such as diabetes, coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). We will take a whole systems approach to reduce the disease burden, reduce inequalities in care and reduce the geographical gaps in mortality.
- End of Life – people will have improved access to end of life care services that place the wishes and needs of the person and the family at the centre of their care
- Mental Health and Learning Disabilities – people will have improved access to effective evidence based services, and many more people will receive personalised care packages designed to meet their individual needs.
- Maternity and Newborns - there will be safer, higher quality maternity care for all women and their babies in Croydon.
- Children and Young People - there will be safer, higher quality, integrated care for children and young people, in clinically appropriate locations and as close to home as possible.
- Primary / Community – integrated care pathways will be delivered across primary, community and secondary care settings to facilitate the delivery of clinically effective care. The emphasis will be on providing care closer to home.
- Urgent Care - we will have access to urgent care services that are fully integrated with the everyday GP services close to where people live. Reduced the demand on Accident & Emergency services will ensure that these services are available to people with life threatening conditions.

1.4. Delivery initiatives

- **Integrated model of health and social care** –we will have integrated community models of care providing a wide range of health services and wellbeing support for people closer to where they live. We aim to integrate the breadth of health and social care to ensure we can ensure effective outcomes, provide a better experience for people and make better use of resources.
- **Better Services Better Value** - our population will have better access to services, better quality care and better health outcomes, through services that are delivered efficiently and making best use of available resources.
- **Quality, Safety and Experience** – people will have improved experience and perception of health and healthcare

1.5. Delivery impact

The impact of our initiatives will be:

- Financially sustainable, quality services
- We will see an improvement in key health outcomes in Croydon
- Services that are delivered across health and social care in an integrated, seamless manner

2. Prevention of Ill Health

Programme Summary

NHS Croydon Clinical Commissioning Group, Croydon Local Authority, Croydon Public Health Services and the NHS Commissioning Board all have a responsibility towards preventing ill health (see Appendix 2) Croydon CCG will ensure we work closely with our partners to help implement prevention and health promotion programmes across primary, community and secondary care to ensure we treat our population appropriately. We will ensure that:

- we include the provision of advice on physical activity as part of other healthcare contracts and promote brief interventions in primary care.
- we include the provision of advice on diet, nutrition and obesity management as part of other healthcare contracts and to promote brief interventions in primary care.
- we commission nutrition as part of treatment services and the provision of dietary advice in healthcare settings.
- we Commission NHS services to treat overweight and obese patients.
- Include the provision of advice on drugs and alcohol as part of other healthcare contracts and promote brief interventions in primary care.
- Working alongside the local authority, commission brief stop smoking interventions in secondary and maternity care and promote brief interventions in primary care.
- Commission NHS treatment and on-going risk management following NHS Health Check assessments.
- Ensure that NHS occupational health services that are commissioned actively promote workplace health.
- Promote early diagnosis as part of community health and outpatient services commissioned.
- Work collaboratively with Public Health England and the council on outbreak control and related activity
- treatment for mental ill health is aligned with mental health promotion, mental illness prevention and suicide prevention programmes, alongside mental health interventions in primary care commissioned by the NHS Commissioning Board.
- we commission appropriate treatment services for children to complement the Healthy Child Programmes for pregnancy to age 5 and for school age children

Provider Impact

Primary care

- Primary care plays a key role in prevention, early detection and management of high risk individuals.
- Delivery of public health interventions commissioned by the local authority, such as NHS Health Checks, as well as opportunistic brief interventions for a range of presenting issues including drugs and alcohol, dietary and weight management advice, stop smoking advice.
- The CCG will act as both a commissioner, ensuring that the services it commissions complement services commissioned by other organisations, and also as an enabler, by mobilising its member practices.

Community and Acute

- Community and acute providers will deliver a range of brief interventions as part of their core contracts for a range of presenting issues including drugs and alcohol, dietary and weight management advice, stop smoking advice. They will also promote early diagnosis including opportunistic testing and treatment.

Social Care and Mental Health

- Where appropriate, services commissioned will aim to closely integrate social care and NHS provision, for example child and adolescent mental health services (CAMHS).

3. Self-Management

Programme Summary

Throughout the themes of our Integrated Strategic Operating Plan and our Commissioning Intentions we will aim to support people to manage their condition so that they can live as full a life as possible. We will ensure that:

Within our core contracts we will

- Include the provision of advice on physical activity as part of other healthcare contracts and promote brief interventions in primary care
- The provision of advice on diet, nutrition and obesity management as part of other healthcare contracts and to promote brief interventions in Primary Care
- The provision of nutrition as part of treatments services and the provision of dietary advice in healthcare settings
- Include the provision of advice on drugs and alcohol as part of other healthcare contracts and promote brief interventions in primary care
- Working alongside the local authority commission brief stop smoking interventions in secondary and maternity care and promote brief interventions in primary care

Provider Impact

Primary care

- Primary Care will deliver as part of their core contracts help and advice on assisting people to manage their illness well and to signpost to other services as appropriate

Community and Acute

- Community and acute providers as part of their core contracts help and advice on assisting people to manage their illness well and to signpost to other services as appropriate

Mental Health

- Mental Health providers as part of their core contracts help and advice on assisting people to manage their illness well and to signpost to other services as appropriate

4. Long-term Conditions

Programme Summary

The overarching aim for Croydon Clinical Commissioning Group is to reduce the number of unplanned admissions and enhance the quality of life for people living with a long term condition. Commissioning strategies are focussed on an integrated model of care for people to address both the health and social care needs of both the person living with the long term condition and their carers.

Croydon's multi-agency Transformation Board will oversee implementation and partnership sign-up to the principles of the transformation agenda and an operational model of integrated health and social care including:

- Roll-out of risk stratification across participating practices.
- Engagement of providers in case management system.
- Development of multi-disciplinary team meetings for case reviews.
- Establish and agree inter-provider clinical governance framework.
- Development of health and social care performance dashboard.
- Pump-priming resources will be available to contribute to increased operational costs, above existing service investments.
- Contract mechanisms, where it will add value, will be introduced through e.g. Local Enhanced Services (LES), Community and Acute contracts and Quality and Outcomes Framework.

Provider Impact

Primary Care

- Up-take of case management, with a progressive roll-out of the model in up to 6 network localities.
- Participation in risk stratification and case management.
- On-going improvements in screening and detection.

Croydon University Hospital (CUH)

- Reduced level of unnecessary admissions to Hospital, particularly for ambulatory care sensitive conditions.

Croydon Community Health Services (CCHS):

- More responsive and productive community services piloting a new model of care.
- The model of care will require new ways of working for acute and community services
- The CCG will require on-going assurance from Croydon University Hospital that workforce development and skill-mix are supported through Continuous Professional Development (CPD).

Mental Health

- Working with Mental Health (SLaM) through integrated pathways and integrated case management for people identified as high risk

Social care

- Working with Social Care through integrated pathways and integrated case management for people identified as high risk

4.1. Continuing Care

Programme Summary

The Continuing Care programme is linked to the work of the Long Term Conditions as people requiring NHS Continuing Healthcare are usually eligible as a consequence of the complexity in their long term condition or at the end stage of their life.

The programme therefore will link with the integrated Health and Social care Models and will organise its services around the network localities and will include

- Development of a Virtual Multi-disciplinary team for clear and consistent decision making with all necessary expertise involved at every level.
- A procurement exercise to stimulate the market and deliver a fair local price for care. This will be completed by December 2012

The Purchased Healthcare Team is running a London Procurement Programme (LPP) with all London clusters to make the most of the purchasing power of the NHS in London and to maximise investment in patient care - helping deliver the highest quality services whilst at the same time ensuring value for money.

The proposed Any Qualified Provider (AQP) procurement process will allow for a review of pricing maximising potential for Clinical Commissioning Groups to control costs when the current LPP contract ends in June 2013 and ensure sustainability of local providers to deliver a high quality standard of care for people eligible for NHS Continuing Healthcare.

Provider Impact

Primary Care

- Good quality standards and practices in homes will ensure the most appropriate use of primary care support and less risk of clinical incidents occurring in homes.

Croydon University Hospital (CUH)

- Reduction in the number of unplanned hospital admissions for NHS Continuing Healthcare patients.

Croydon Community Health Services (CCHS):

- Care is delivered to a high standard within the home.

4.2. Mental Health

Programme Summary

The emphasis on Mental Health services is to deliver a higher proportion of mental health services in a primary care setting, by increasing the mental health skills in the primary care workforce, and by procuring re-designed primary/community mental health services. The Primary Mental health Pathways project will be continued, to further shape the way intermediate services can support primary care clinicians. Programmes will include:

Intermediate services – a new intermediate service will be piloted from January 2013, running well into 2013/14. The service will be closely monitored and reviewed, with the intention to expand and adapt the service as necessary. There will be accompanying developments in prescribing protocols for shared care.

Re-ablement - a mental health re-ablement service will be piloted for a year from January 2013. The service is designed to provide an improved service option for clients diagnosed with serious mental illness (SMI), who would ordinarily be accepted for care-coordination support delivered by the South London and Maudsley (SLaM) secondary mental health service. It will test the hypothesis that re-ablement can divert people with health and social care needs

arising from SMI from the most intensive forms of acute (inpatient and community) service provision available. If effective, over a short period of time, re-ablement will offer adults diagnosed with SMI quick access to brief health and social care interventions. The aim is to restore or develop clients' independence from mental health services, enabling them to rely, instead, on innate strengths, including family and social networks, extant prior to engagement with services. It is planned to make this service sustainable in the second half of 2013/14.

Personalisation - increased provision of self-directed support services and personalised budgets for people with mental health problems remains a high priority for the NHS and the Council. A pricing scheme was introduced in April 2012 to assist the transition from block contracting to individual purchasing, for people receiving self-directed support. The scheme will be reviewed in January 2013 with a view to wider roll-out in 2013/14.

Early Intervention - the commissioning of preventive services has been established by the recent Programme Budget Review. Further consideration will be given to the development of a more effective pathway into and through secondary mental health services, with more specific proposals to be outlined by April 2013.

Dementia: Implementation of Croydon's new joint health and social care strategy for dementia, based on the 2011/12 Joint Strategic Needs Assessment. Priority actions include:

- Increasing the rates of early diagnosis;
- Improving access to carer support services for carers of people with dementia;
- Developing an integrated acute hospital dementia pathway;
- Continuing the improvement of NHS Continuing Care pathways for people with dementia.

Provider Impact

South London and Maudsley Trust

- Transfer of care from inpatient setting to intermediate services

5. Maternity and New-borns

Programme Summary

We plan to build on the Partnership approach for Maternity and Newborn care. We will ensure:

- support of vulnerable families and improve identification and access to early support.
- Contribute to the Family Engagement Partnership (FEP) in each of the 5 children's centre collaborations across the borough to deliver integrated services for pre-birth to 2 years.
- engagement of maternity services in the Early Intervention programme, increasing their networking with children's centre collaborations and their populations.
- appropriate pathway service design and delivery to promote normality of birth.
- improvement of the Midwife to births ratio
- participation in the South West London Maternity Clinical Network to optimise outcomes as Better Services Better Value is implemented.
- collaborative approaches with the sector where there is no critical staff mass e.g. to increase the number of home births.
- review the local position against the findings of the Maternity Standards Project.

Provider Impact

Primary Care

- To help facilitate access to pre-natal services early, within 12 weeks and 6 days for pre-natal care.
- To be active partners with their local network of services, including children's centres, health visiting teams and Family Engagement Partnerships.
- To deliver responsibilities towards safeguarding children, including appropriate assessment, intervention and liaison.
- Primary Care will deliver as part of their core contracts help and advice to maximise health and well being and to signpost to other services as appropriate, e.g. breast feeding support services.

Croydon University Hospital (CUH)

- To increase ratio of Midwives to Births
- To work with the Maternity Services Networks and commissioners to respond to the changes expected in demand and capacity following progression of *Better Services, Better Value.*
- To be active partners with their local network of services, including children's centres, health visiting teams and Family Engagement Partnerships.
- To deliver responsibilities towards safeguarding children, including appropriate assessment, intervention and liaison.

Croydon Community Health Services (CCHS):

- To increase the number of women with a named midwife throughout their pathway experience.
- To be active partners with their local network of services, including children's centres, health visiting teams and Family Engagement Partnerships.
- To deliver responsibilities towards safeguarding children, including appropriate assessment, intervention and liaison.

Social Care

- To work collaboratively to ensure children and young people's needs are met with an appropriate level of response.

6. Children and Young People

Programme Summary

Across the Partnership and Every Child Matters domains, current priorities overseen by the Partnership Working sub-group are linking Clinical Commissioning Group with the health and well-being board, improved performance management

We will:

- To work with the Local Authority to complete implementation of the Early Intervention Programme, including fully operational Family Engagement Partnerships, and alignment of services children's centre populations
- Removed (LA have de-prioritised LSBs at the moment)
- Contribute to and access multi agency training to embed integrated practice and local networks
- deliver against the local outcomes based performance framework to be monitored and framework adjusted, as appropriate, to align outcome goals across agencies, enhancing its effectiveness in informing commissioning e.g. reporting across agencies for population targets e.g. breastfeeding
- continue to support the delivery of national policy for Health Visiting and School Nursing, including Family Nurse Partnership
- ensure on-going improvements in access to Children and Adolescent Mental Health Services (CAMHS), future commissioning to be informed by the 2012-13 Joint Strategic Needs Assessment (JSNA).
- Working with the Local Authority to improve service access, in particular for children and young people with Autism Spectrum Disorders (ASD), Attention Deficit Hyperactivity Disorder (ADHD), and for children and young people with learning difficulties and disabilities with challenging behaviour.
- full implementation of the Improving Access to Psychological Therapies (IAPTs) project, considering sustainability of this project going forward.
- consider impact on health services of Local Authority proposals to increase number of school places in Croydon, particularly for those with Special Educational Needs.
- Work with the Local Authority on the expansion of existing joint commissioning arrangements, including therapies and equipment.

Provider Impact

Primary Care

- To be active partners with their local network of services, including children's centres, health visiting teams and Family Engagement Partnerships.
- To deliver responsibilities towards safeguarding children, including appropriate assessment, intervention and liaison.
- Primary Care will deliver as part of their core contracts help and advice to maximise health and well-being and to signpost to other services as appropriate

Croydon University Hospital (CUH)

- To be active partners with their local network of services, including children's centres, health visiting teams and Family Engagement Partnerships.
- To deliver responsibilities towards safeguarding children, including appropriate assessment, intervention and liaison.

Croydon Community Health Services (CCHS)

- To increase ratio of Health Visitors to children under 5 years population.
- To align services with children's centre collaborations to facilitate improved integration of services.
- To be active partners with their local network of services, including children's centres, health visiting teams and Family Engagement Partnerships.
- To deliver responsibilities towards safeguarding children, including appropriate assessment, intervention and liaison.
- To increase coverage of the Healthy Child Programme, particularly for under 1 year reviews and 2 – 2.5 year reviews.

Mental Health

- To reduce hospital admissions and lengths of stay.
- To further develop targeted services for the management of intensive and complex mental health needs in the community.
- To help build expertise across the children's workforce for prevention and early intervention services.

Social care

- To work collaboratively to ensure children and young people's needs are met with an appropriate level of response.

7. Planned Care

Programme Summary

The overall strategic aim for planned care is that where possible, care is managed within the primary care environment, ideally by the patient's registered GP, or through the provision of Intermediate care services at a locally agreed tariff.

To support the overall strategic aim referral and clinical pathways have and / or are being developed to ensure that care is streamlined and that the person is seen in the 'right place' at the 'right time' with as few steps in the pathway as possible.

In order to meet the overall strategic aims above the following initiatives are planned for 2013/14:

Primary Care Referrals

Croydon CCG seeks to improve the quality and appropriateness of referrals received by secondary care, as well as to ensure that people are seen in the most appropriate care setting to meet their clinical need: This will be achieved through the roll out of the Croydon Referral Support Service (CReSS) from 18 practices to 61. Focus will be on achieving behavioural change in GP referral patterns which will include re-directing referrals back to GP's where appropriate for on-going management, directing referrals to alternative intermediate Providers and only referring to the acute environment where indicated for specialist advice and treatment.

Expansion of Intermediate Care Services

Croydon CCG will, throughout 2012/13 be reviewing further expansion of intermediate service provision to new specialities. It is anticipated that case mix data provided by CReSS will help to inform the provision of future intermediate care services. Initial focus will be on areas of high cost or over performance in 2011/12, these include;

Ophthalmology - development of an ophthalmology pathway and procurement of a comprehensive intermediate ophthalmology service in 2013/14 which it is anticipated will have a significant reduction in ophthalmology outpatient and potentially elective activity, including cataract activity.

Cardiology - development of a cardiology pathway and potential procurement of an intermediate cardiology service in 2013/14 which will impact on cardiology outpatient and elective activity.

Dermatology - piloting a community-based service which utilises new technologies to aid the diagnosis of skin cancers. This is intended to reduce the number of 2-week wait Dermatology referrals sent to the Trust.

Anti-coagulation - reviewing the anti-coagulation service to assess how people on long term warfarin can be managed safely within the community setting, this will have a subsequent reduction of capacity in the acute setting.

Direct Access Diagnostics - pathways will be further streamlined by widening the availability of direct access diagnostics, coupled with unbundling of tariff where people are subsequently referred into hospital.

Direct Listing - number of procedures that can be direct listed will be expanded and these will be able to be accessed by Intermediate provider services, Croydon GPs or other relevant specialists (i.e. pharmacists, Allied Health Professionals). This will impact on first outpatient activity and on pre-operative assessments in Acute Trusts.

Day case - reviewing where day case / outpatient procedures can be appropriately provided in a primary care setting at locally determined tariffs: Croydon will review existing day case spend on drug infusions to determine scope for provision in a community session and/or negotiation of local tariff.

Patient Navigation - will continue to streamline the patients' outpatient journey through further expansion of Patient Navigation to:

a) other outpatient specialities, example nephrology and diabetes, where F:FU ratios are high
b) better utilisation of telephone clinics for the management of patients with chronic conditions, and
c) identifying variation in consultant management of care, which may lead to the development of locally defined best practice pathways

Waiting List Validation - will run Waiting List validation audits to enable GPs to identify where elective care is no longer wanted/required for their patients.

Outpatient Parenteral Antimicrobial Therapy Service - Croydon CCG will be exploring options for the delivery of IV antimicrobial therapy in the non-in-patient setting; outpatient clinics, community nursing in the patient's residence, through home care with nurse administration or self-administration by the patient. A multidisciplinary OPAT service, either in the acute or community setting provides the structure for safe transfer and monitoring of these patients.

The benefits of an OPAT service are well documents:

- Improved patient choice and satisfaction
- Reduced risk of hospital acquired infection
- Improved antimicrobial stewardship

- QIPP efficiency gains from early discharge or avoided hospital admissions. OPAT episodes of care are estimated to cost around 50% of equivalent inpatient costs

The CQUIN framework could be used to provide the 'pump priming' funding to establish the business case and pilot the service with the aim for the service to become self-sustaining for the future.

Local Enhanced Services – a review of Local Enhanced Service is currently under review and a basket of planned LES may be commissioned as a result of this review.

Negotiation of Local Tariffs - will work with Acute Commissioning Unit colleagues to benchmark spend in acute setting and identify areas where Croydon is an outlier in terms of spend. Where it is though this is due to irregularities in coding (i.e. Early Pregnancy Unit, Consultant to consultant referral rates) commissioners will seek to mitigate through correction of coding errors or negotiation of local tariff.

Provider Impact

Primary Care

- All 61 GP Practices engagement with CReSS
- Full engagement by all practices in enhanced services that serve to reduce acute activity/spend will be key to recovering a surplus budget position for Croydon. This may include the development of a Hub and Spoke model of care between network localities

Croydon Community Health Services (CCHS)

- Community services will be required to support improved pre-operative and post-surgical care.

Acute Hospitals used by Croydon Residents

- Reduction in first to follow up ratios to achieve national upper quartile performance in this area.
- Decrease in Outpatient specialities, for example: Ophthalmology and Cardiology.
- Further decreases in Dermatology and Anti-coagulation activity as detailed above.
- Decommissioning of further day-case / outpatient procedure activity. First area for review is drug infusions, and whether there is scope for provision in a community setting and/or negotiation of local tariff.
- Reduced elective activity through Waiting List validation audits to enable GPs to identify where elective care is no longer wanted/required for their patients.
- Review of activity through planned care initiatives and the potential to decommission some services, example reduction in outpatient clinics and day case wards.
- Review of services that the Trust would like commissioned from other Providers
- Negotiation of local tariff for Early Pregnancy Unit (EPU) activity
- Achievement of the milestones set out in the proposed CQUIN for the OPAT service

Social care

- Engage in multi-disciplinary pre-operative assessment of people, where appropriate to support earlier discharge, reduction length of stay and reduced excess bed days / re-ad mission for non-clinical reasons.

South London and Maudsley Mental Health Trust (SLaM)

- Engage in multi-disciplinary pre-operative assessment of people, where appropriate to support earlier discharge, reduction length of stay and reduced excess bed days / re-ad mission for non-clinical reasons

8. Urgent Care

Programme Summary

By 2015 we will have access to urgent care services that are fully integrated with the everyday GP services and Community Pharmacy Services close to where people live. Reduced demand on Accident & Emergency services will ensure that accident and Emergency Services are available to patients with life-threatening conditions.

Review of Urgent Care Services and Unscheduled Pathways this will include

- Review of all activity to Emergency Department by age, day of week and time of day
- Review of all activity to Urgent Care Access Points by age, day of week and time of day
- Review of all activity to GP Led Health Centre with walk in Centre by age, day of week and time of day
- Review of Primary Care Extended Hours in relation to use of unscheduled care services

Provider Impact

Further to the work which has commenced on Urgent Care / OOHs redesign and NHS 111, commissioners intend to develop Urgent Care services further in line with the following objectives:

Primary Care

- To have easier access in Primary Care for same day appointments for people requiring an unscheduled appointment

Croydon University Hospital (CUH)

- Emergency department to ensure closer working with Front End Urgent Care Centre to ensure achievements of national targets

- Strengthen integration between community and acute services

Urgent Care Centres / Walk in Centre

- To ensure adequate signposting along the unscheduled care pathway to ensure the person is seen in the most appropriate setting including Primary Care and Pharmacy

9. Medicines Optimisation

Programme Summary

NHS Croydon CCG through Medicines Optimisation is ensuring that we get 'the most out of medicines and are making best use of medicines'. In Croydon this encompasses all aspects of medicines use from decisions about which medicines should be used, to how they are supplied and how they are used.

To be successful, medicines optimisation needs professionals across the health and social care system and primary and secondary care interface to work together in an integrated model of care to support people closer to where they live. There are a number of joint initiatives in Croydon including an area prescribing committee across the whole health economy and joint medicine optimisation projects with the Local authority. The aim for this year is to build on this using the Commissioning for Quality and Innovation (CQUIN) framework where success depends on joint working with CUH

The Primary Care Prescribing budget efficiency savings for 2013-14 will be delivered through an annual prescribing work plan that will incorporate London Procurement Medicine Management Quality, Innovation Productivity and Prevention (QiPP) indicators, National Institute of Clinical Excellence (NICE) and other national patient safety guidance.

Growth in Payment by Results (PbR) excluded drugs is currently running at 18% per annum for Croydon Health Services and is mainly driven by NICE implementation. We will explore if there are efficiencies to be gained from procuring the most cost effective drug choices without compromising the persons care.

Provider Impact

Clinicians across all local providers will be expected to prescribe in line with the Croydon Prescribing Committee recommendations and engage with the economy-wide process for management of the entry of New Drugs and NICE implementation.

Primary Care

Practices will be expected to continue to engage with the delivery of the Primary care Prescribing QIPP plan, through and annual prescribing review, Medicines Management Quality Outcomes Framework (QOF) targets and participation in the annual prescribing incentive scheme

Community pharmacists delivering medicine use reviews in domiciliary settings and in care homes will continue to be monitored for activity and quality of interventions.

Croydon University Hospital (CUH)

- Joint working on medicine optimisation and transfer of care initiatives to improve medicine safety and support patients in getting the best for their medicines.
- Key Performance Indicators (KPI's) and elements of the medicine management CQUIN to support the Primary Care prescribing QIPP delivery
- Gain share agreement for the management of growth in PbR excluded drugs

Croydon Community Health Services (CCHS):

Joint working with community teams on medicines optimisation and initiatives to support improvement in the quality and cost-effectiveness of prescribing products for woundcare and nutrition.

Social care, mental and community health care services:

Continuation and expansion of joint projects to improve medicines safety such as the pharmacy re-ablement domiciliary medicine use reviews (MURs), Pharmacy service on Partnership for Older people bus.

10. Priority Draft Commissioning Intentions

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
1. Improving Prevention and Early Detection				
1.1	Prevention	The CCG intends to commission as part of core service a focus on prevention and health promotion and to deliver strategic aims set out within the Primary Care Strategy	Longer Term impact on Clinical and Financial Outcomes	Primary Care
1.2	Early Detection	The CCG intends to commission as part of core service a focus on prevention and health promotion and to deliver strategic aims set out within the Primary Care Strategy	Medium to Longer Term impact on Clinical and Financial Outcomes	Primary Care
1.3	Prevention and Early Detection	The CCG intends to commission strategic Local Enhanced Services in a range of settings to focus on prevention and early detection priorities. Alignment of public health campaigns with all providers	Medium to Longer Term impact on Clinical and Financial Outcomes	Primary Care
1.4	Early Intervention	The CCG intends to jointly develop (with the Council) a more effective pathway into and through secondary mental health services	Medium to Longer Term impact on Clinical and Financial Outcomes	Primary Care and Secondary SLaM MH services
1.5	Prevention and Early Detection	Risk identification and structured roll-out of lifestyle and pharmacological interventions (e.g. Metformin, Orlistat) for individuals at high risk of Type 2 Diabetes who are unable to benefit from intensive lifestyle programmes	Prevent and delay onset of diabetes and associated complications	Primary Care
1.6	Prevention	Review current implementation of DH Healthy Start Programme to prevent and reduce vitamin D deficiency	Medium to Longer Term impact on Clinical and Financial Outcomes	Primary Care Croydon Community Health Services (CCHS) Croydon University Hospital (CUH)

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
2. Self-Management				
2.1	Re-ablement	Roll out Telehealth and commission appropriate therapy services to support re-ablement programmes to promote quality of life and independence	Reducing Re-Admission Rates	CUH Community Services (CCHS)
2.2	Rehabilitation	To work with the Local Authority to further develop the service and ensure seamless transfers between health and social care to enable safe and timely discharge	Reducing Re-Admission / Lengths of Stay	CUH Community Services (CCHS)
2.3	Reablement	To pilot a mental health re-ablement service	Reduced length or treatment / rapid solutions/diversion from acute service	SLaM Inpatient & Community MH Services
2.3	Education	Roll out of accredited structured education for people with diabetes through the AQP process e.g. DAFNE, DESMOND, XPERT.	Keeping people well reducing need for hospital admissions	Primary Care Community Services (CCHS)
2.4	Medicines Optimisation	CUH CQUIN to include • CUH CQUIN to include: Medicines reconciliation on admission and discharge • Quarterly audit report on drug – related admissions • At risk patients receive appropriate referral to c to a primary care service • Improvement on communication on discharge • Medicines Information Helpline for patients post-discharge • Implementation of national and local safety initiatives e.g. insulin passport, inhaled corticosteroid card	Reducing drug related re-admissions	Community Services (CCHS) Croydon University Hospital (CUH Primary Care

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
2.5	Medicine Optimisation	KPI re Implementation of a Working with the Industry Policy at Croydon University Hospital (CUH)	Improvement clinical and cost-effective management of prescribing	Primary care Community Services (CCHS) Croydon University Hospital (CUH)
2.6	Primary care CQUIN programme	CQUIN -Increase percentage of wound formulary products prescribed, Decrease NIC/item of wound management products. X% staff receiving annual training	Improved clinical and cost effectiveness of Wound Management	Primary Care Community Services (CCHS) Croydon University Hospital (CUH
2.7	Primary Care CQUIN Programme	CQUIN – use of agreed documentation for assessment of malnutrition and for ordering of supplement prescriptions. X% staff receiving annual training	Improved clinical and cost effective prescribing for Nutrition	Primary Care Community Services (CCHS) Croydon University Hospital (CUH
2.8	PbRe Excluded drugs (High Cost Drugs)	Use the SWL framework to develop a gain share agreement that incentivising the provider to procure more cost-effective High Cost Drugs (HCD) without compromising patient care	Reduction in growth of HCD costs	Primary Care Community Services (CCHS) Croydon University Hospital (CUH)
3. Long Term Conditions includes Continuing Healthcare / Mental Health				
3.1	Integrated Model of Care	Integrated working around network localities	Reduce non-elective hospital admissions	Community Services (CCHS) Primary Care Social Care
3.2	Pathway Development	Review and develop where identified Pathways outlining trigger points and referral points across services	Reduce duplications in service delivery and to shift persons care to most appropriate Place	Croydon University Hospital (CUH) Community Services (CCHS) Primary Care Social Care

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
3.3	Risk Stratification	Procurement of risk stratification model	Reduce non-elective admissions high risk group	Croydon University Hospital (CUH) Community Services (CCHS) Primary Care Social Care
3.4	Case Management	Strategic 'Local Enhanced Services' to include component of Case Management	Reduce non-elective admissions high risk group	Primary Care
3.5	Case Management	Review of all current Community Services offered for Long Term Conditions and Elderly Frail	Reduce non-elective admissions high risk group	Community Services (CCHS)
3.6	Telehealth	Extension of Telehealth to Diabetes and COPD	Reduce non-elective admissions high risk group	Croydon University Hospital (CUH) Community Services (CCHS))
3.7	NHS Continuing Healthcare	To review fair pricing structure with Care Homes. To drive up quality standards through commissioning on the basis of 'Any Qualified Provider'	Effective management NHS Continuing Healthcare budget	Care Homes Nursing
3.8	End of Life Care	To develop and integrate palliative care rapid response clinical service with social care palliative support (St Christopher's)	Reduce risk of hospital admission last days of life	CUH Hospice Roll out of Pilot ? Procurement
3.9	Dementia	Implement the joint health & social care strategy for dementia, including improved pathways for acute hospital care and continuing care	Increased rates of early diagnosis, better access to carer support	Croydon University Hospital (CUH) SLaM Independent Providers
3.10	Complex Mental Illness	Continue to systems manage all high cost/long term mental health placements for people with serious mental illness	Reduced length of stay in high cost placements, especially forensic and	Independent Providers SLaM

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
			autism spectrum disorder (ASD) beds	
3.11	Oxygen Assessment	Patients with persistent Hypoxemia (PO2 <7.3kPa) should be assessed before leaving hospital and oxygen supply provided. These patients should be reassessed within 8 weeks (not earlier than 6 weeks to ensure stable) to decide whether Long Term Oxygen Therapy (LTOT) is indicated	Reduced readmissions	Croydon University Hospital (CUH) Community Services (CCHS)
3.12	Long Term Conditions Management	To achieve best practice tariff standards for paediatric diabetes	Fewer admissions and complications of diabetes such as blindness, kidney failure	Croydon University Hospital (CUH) Community Services (CCHS)
3.13	Long Term Conditions Management: Respiratory	Following evaluation of the COPD Hot Clinic CCG to consider whether expanding the service to other Respiratory conditions.	Potential for reduced A&E attendances and Emergency Admissions (if evaluation proves positive)	Croydon University Hospital (CUH)
4. Maternity / Children and Young People				
4.1	Maternity	Increasing % ratio of Midwives to mothers	Reduce % of stillborns and low weight babies	CUH
4.1	Mental Health	Improving access to CAMHS and reviewing arrangements for Tier 3 and 4	Reduce risks of mental ill health	SLaM
4.2	Breast Feeding	Increasing numbers of ratio of Health Visitors	Reduce risks of obesity / cancer	Community (CCHS)
4.3	Children's Centres	Organising services around x5 Children's Centres	Reduce duplication in service	Community (CCHS) Children's Centres

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
5. Planned Care				
5.1	Reducing Demand on Secondary Care Outpatients	For CCG to consider and review further KPIs around First to Follow Up Ratio's	Reduce numbers of Follow Up OPA appointments	Croydon University Hospital (CUH) and Acute Trusts used by Croydon residents
5.2	Reducing Demand on Secondary Care Outpatients	For CCG to consider and review transfer of high use ophthalmology to an intermediate care setting	Reduce numbers of First & Follow Up OPA appointments	Croydon University Hospital (CUH) and Acute Trusts used by Croydon residents Procurement of Service - opportunities for new and existing Providers
5.3	Reducing Demand on Secondary Care Outpatients	For CCG to revise cardiology pathways and consider transfer of Cardiology activity to an intermediate care setting	Reduce numbers of First & Follow Up OPA appointments	CUH and Acute Trusts used by Croydon residents Primary Care Procurement of Service - opportunities for new and existing Providers
5.4	Reducing Demand on Secondary Care Day Case/Outpatient Procedures	For CCG to consider and review transferring some Day Case and outpatient procedure activity from Secondary Care	Reduce Day-case and Outpatient procedure activity, shifting care closer to home. Reduction in costs through development of local tariffs	CUH and Acute Trusts used by Croydon residents Procurement of Service - opportunities for new and existing Providers
5.5	Shared Care	Increasing clinical areas to share care example mental health medications.	Reducing numbers of Outpatient Appointments	Primary Care SLaM
5.6	Mental Health	Strengthening the capacity of primary care, developing an	Greater numbers receiving primary	SLaM

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
	Services Closer to Home	intermediate service and improved prescribing protocols for shared care	MH services, reducing activity in secondary MH services	Primary Care
5.7	Patient Navigation	Roll out of Patient Navigation to all Outpatient Specialities	Reduce numbers of unnecessary/non-value adding Outpatient appointments	CUH and Acute Trusts used by Croydon residents
5.8	CReSS	Roll out of CReSS to all GP Practices and evaluation by Practice of referral patterns into Secondary Care and Intermediate Services. Also look to increase the numbers of people managed within their registered GP Practices	Reduce numbers of unnecessary outpatient appointments	Primary Care Intermediate Services
5.9	Effective Clinical Commissioning	To review all intermediate services against principles of ECI and growth in overall activity	Assurance that ECI is being followed throughout the health economy	Primary Care Intermediate Services
5.10	Psychological Services	Review access to Psychological Therapies.	To meet national targets and guidelines	Primary Care Intermediate Services CUH and Acute trusts used by Croydon residents SLaM
5.11	Outpatient Parenteral Antimicrobial Therapy	Use the CQUIN framework to pump prime the development of a (self-sustaining) OPAT service to facilitate the safe administration of antimicrobials in the non-inpatient setting	Reduced LOS, admission avoidance	CUH Community

No	Area	Proposed Action	Expected Outcomes	Providers Affected (e.g. acute, community)
6. Urgent Care				
6.1	Emergency Attendances	Review of Urgent Care Model all access points – demand and capacity	Reduce access points, more responsive Primary Care	CUH Virgin UCC Services Primary Care
6.2	Non Elective Admissions via A&E	Review of contract levers	Meeting 4 hour waiting times, reduce attendance /admissions ratio	CUH Virgin UCC Services
6.3	Non – elective admissions from home	Review of emergency admissions for older people from HOME and consider gaps in service within Integrated Pathway Model	Reduction in Non-Elective Admissions	CUH Community Services (CCHS) Primary Care
6.4	Non elective admissions from Care Homes	Review of emergency admissions for older people from CARE HOMES and consider gaps in service within Integrated Pathway Model	Reduction in Non –Elective Admissions from	CUH Care Homes Community Services (CCHS) Primary Care
6.5	Non Elective Admissions	Review of emergency admissions for all adults and a specific review of geographical areas where admissions are higher	Reduction in Non –Elective Admissions	CUH Community Services (CCHS) Primary Care

11. Aligned Pathway Commissioning Intentions

Please note that the table below is in draft, Croydon Local Authority Commissioning and Public Health and Croydon Clinical Commissioning Group are working collaboratively to ensure that for each function, pathways are mapped across organisations.

Commissioning Functions	Local Authority / Public Health	CCG Commissioning	Related NHS CB commissioning
Primary Care - GP Practices		Out-of-hours primary medical services (where practices have opted out of providing OOH services under the GP contract) Community-based services that go beyond scope of GP contract (akin to current Local Enhanced Services) [2]	Essential and additional primary medical services through GP contract and nationally commissioned enhanced services Out-of-hours primary medical services (where practices have retained the responsibility for providing OOH services)
Primary Care - Pharmacy		Meeting the costs of prescriptions written by member practices (but not the associated dispensing costs)	Pharmaceutical services provided by community pharmacy services, dispensing doctors and appliance contractors
Primary Care – Ophthalmology		Any other community-based eye care services and secondary ophthalmic services	Primary ophthalmic services, NHS sight tests and optical vouchers
Primary Care – Dental	Dental public health		Epidemiology, dental screening and oral health improvement, including water fluoridation All dental services, including primary, community and hospital services and including urgent and emergency

Commissioning Functions	Local Authority / Public Health	CCG Commissioning	Related NHS CB commissioning
			dental care
Veterans and Reservists		Health services for veterans or reservists (when not mobilised), for whom normal commissioning responsibilities apply Emergency care, including A&E and ambulance services, for serving armed forces & families registered with DMS practices present in the geographic area	Health services for members of the armed forces and their families (those registered with DMS) Prosthetics services for veterans (Primary care for members of the armed forces will be commissioned by the Ministry of Defence)
People in Prison		Emergency care, including 111, A&E and ambulance services, for prisoners and detainees, Health services for adults and young offenders serving community sentences and those on probation Health services for initial accommodation for asylum seekers	Health services (excluding emergency care) and public health services for people in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children's homes, secure training centres, immigration removal centres, police custody suites)
Urgent and Emergency Care		Urgent and emergency care (including 111, A&E and ambulance services) for anyone present in the geographic area Out-of-hours primary medical services (for everyone present in the area), except where this responsibility	Urgent care provided under GP contracts Urgent dental care

Commissioning Functions	Local Authority / Public Health	CCG Commissioning	Related NHS CB commissioning
		has been retained by practices under the GP contract	
		Elective Hospital Care Community health services (such as rehabilitation services, speech and language therapy, continence services, wheelchair services, and home oxygen services, but not public health services such as health visiting and family nursing) Other community-based services, including (where appropriate) services provided by GP practices that go beyond the scope of the GP contract Rehabilitation services	Specialised and highly specialised services Hospital and community dental services
Maternity and Newborns	Population level interventions to reduce and prevent birth defects (with PHE)	Maternity and newborn services (excluding neonatal intensive care)	Interventions in primary care such as pre-pregnancy counselling or smoking cessation programmes Some specialist genetic services Antenatal and newborn screening aspects of maternity services
Children's Public Health 5-19	e.g. Healthy Child Programme for	Treatment services for children,	

Commissioning Functions	Local Authority / Public Health	CCG Commissioning	Related NHS CB commissioning
	school-age children, including school nursing	including child and adolescent mental health services (CAMHS)	Healthy Child programme (pregnancy to five years old), including health visiting and family nurse partnership Immunisation programmes
Infertility Services		Infertility Services	Infertility services for the armed forces and some infertility services for veterans in receipt of compensation under the Armed Forces Compensation Scheme on grounds of infertility
Mental Health	Mental health promotion, mental illness prevention and suicide prevention	Mental health services (including psychological therapies) Treatment for mental ill health	Mental health interventions provided under GP contract Some specialised mental health services Secure psychiatric services
Services for people with learning disabilities		Services for people with learning disabilities	
NHS continuing healthcare		NHS continuing healthcare	Operation of Independent Review Panels
Sexual health	Contraception over and above GP contract Testing and treatment of sexually transmitted infections (excluding HIV	Promotion of opportunistic testing and treatment Termination of pregnancy services (with consultation on longer-term	Contraceptive services commissioned through GP contract Sexual assault referral centres HIV treatment

Commissioning Functions	Local Authority / Public Health	CCG Commissioning	Related NHS CB commissioning
	treatment) Sexual health advice, prevention and promotion	arrangements) Sterilisation and vasectomy services	
Physical activity	e.g. Local programmes to address inactivity and other interventions to promote physical activity	e.g. Advice as part of other healthcare contacts	e.g. Brief interventions in primary care
Obesity programmes	e.g. Local programmes to prevent and address obesity, e.g. National Child Measurement Programme and weight management services	e.g. Advice as part of other healthcare contacts NHS treatment of overweight and obese patients	e.g. Brief interventions in primary care Some specialist morbid obesity services
Drug misuse	Drug misuse services, prevention and treatment	Advice as part of other healthcare contacts	Brief interventions in primary care
Alcohol misuse	Alcohol misuse services, prevention and treatment	Alcohol health workers in a variety of healthcare settings	Brief interventions in primary care
Tobacco control	Local activity, including stop smoking services, prevention activity, enforcement and communications	Brief interventions in secondary care and maternity care	Brief interventions in primary care
Nutrition	Any locally-led initiatives	Nutrition as part of treatment services, dietary advice in healthcare settings	Brief interventions in primary care
NHS Health Checks	Assessment and lifestyle interventions	NHS treatment following NHS Health Check assessments and ongoing risk management	Support in primary care for people with long term conditions identified through NHS Health Checks
Health at work	Any local initiatives on workplace	NHS occupational health services	

Commissioning Functions	Local Authority / Public Health	CCG Commissioning	Related NHS CB commissioning
	health		
Accidental injury prevention	Local initiatives such as falls prevention services		
Seasonal mortality	Local initiatives to reduce excess deaths		Flu and pneumococcal vaccination programmes