Chiltern CCG
Draft Commissioning Intentions
2016/17

Process

- Long-list from gap analysis of current services
  - Joint Strategic Needs Assessment
  - Member input: PLT session; locality meetings
  - Public input: Governing Body meetings; AGM; complaints
- Discussions by JETs and portfolios to produce draft short-list (attached)
- Executive and Governing Body
- Next steps:
  - Feedback to members
  - Share with AVCCG, HWBB and providers (August-October)
  - Base material for 16/17 operating plan – (November/December)

Urgent Care I

Commissioning intention	
PROCUREMENT - OOH,111 & MIIU (partnership with AVCCG)	• Single number – 111 for OOH health needs • Booked right service • Telephone consultations and advice
INTEROPERABILITY - Health records available to the clinician treating Bucks patients	• Buckinghamshire has a summary care record and has invested in **implementing a Medical Interoperability Gateway** which is currently being rolled out across urgent care including ED and OOH. In addition joint working between BHT and our OOH provider is making available recently test results on-line to OOH clinicians, giving them similar access to in-hours GPs and improving the response for patients.
Increasing Resilience in Primary Care	• Promote use of Alamac system to capture and report on capacity/escalation pressure in Primary Care. Encourage continued support for admission avoidance services through the UC Forums. • **GP Earlybird -** Re-evaluate service over winter 15/16 and mainstream
Increasing Resilience through care homes	• **Management Processes** - Implement discharge process with G.P lead in acute setting. • Ensure equity of access to services for residents of care homes to promote self help and avoid acute admissions. • **GP Engagement** - Equitable support to G.P's for their residents in care homes. Work with planning department on allocation/location of new homes.

Urgent Care II

Commissioning intention	
The focus on the front end of the urgent care system - **Prevention. Self care, signposting and self-management**	• Information to patents for right treatment at the right place). Electronic, Social media & Printed material • Making best use of local pharmacies, dentists, voluntary and other services in addition to GP surgeries for self-help • **MAG** - implementation of MIG data sharing. Examine new ways of working especially post discharge in >75yr age group
The focus on the front end of the system - **Out of hospital avoidance services**	Expansion in the scope of existing services • rapid response community nursing and therapy service • Night sitting service • Multidisciplinary Day Assessment Service • **PACE / REACT** or similar teams at the front of all acute services. Support continued roll out of BRAVO. • **ACHT** - Ensure greater visibility of performance across the Localities and ensure equitable access to services.
The focus on the front end of the system - **Out of hospital avoidance services**	• **Design CQUIN** for community geriatric assessment on >75yrs acute admissions to help reduce LoS and support care closer to home • **MuDAS** is seen as a key element of a community care strategy for the future. Consider extended hours / 7 day working to support wider community needs

Urgent Care III

Commissioning intention	
A focus on the services commissioned once a patent requires **urgent hospital care (A&E)**	• Develop a system whereby all patients discharged from the acute setting have timely discharge summaries electronically sent to their G.P practice, thus promoting integrated and safe continuous care. Continue roll out od e-discharge.
A focus on the services commissioned once a patent requires **urgent hospital care (same day hospital care)**	• Continue to support AEC pathways for suitable patients. Encourage culture of "All patients are ambulatory unless otherwise indicated by medical need
A focus on the services commissioned once a patent requires **Discharge**	• EDD for all admissions • **Home not hospital** - Commission pre-paid packages of care where appropriate. (e.g in escalation and on Bank Holidays) Commission home from hospital services to support timely discharge and care closer to home. • **GP discharge project** - Implement discharge process with G.P lead in BHT (replicate Wexham model) • **GP Engagement** - Continued education of the discharge planning processes and services available to support patients on discharge
Strategic	• CCG will work across the Thames Valley Network to scope the model of an integrated urgent and emergency care model as outlined in the vanguard bid

Children, Young people & Maternity I

Commissioning intention	
Support **BHT Children's Services Improvement Board** workplan (response to recent CQC)	• Ensure that there is transparency of **waiting times** and improvements where indicated for children who require planned care or are referred for community paediatric assessment • Ensure that health services for **Looked After Children** comply with Statutory Guidance • Build on the strong Joint Commissioning arrangements with Bucks CC (social care and education) to ensure that Children's services deliver **Early Help** and support to families with children who have additional and **complex needs**
Mental Health	• Ensure the embryonic **perinatal mental health service** achieves NICE compliance, is responsive and well evaluated • Ensure that the new model for **CAMHS** that is to be launched from October 2015 delivers the improved responsiveness and capability with its intended benefits to young people and their carers • In response to stakeholder feedback , work with providers to Improve **transitions** between **CAMHS and Adult Mental Health** Services and transitions into adults services for those with a **learning disability**
Special educational needs and disability	• Work with partners in social care and education to deliver the SEND reforms
Therapies	• Build on scoping work undertaken in 2015/16 to develop a specification and launch a procurement process for an Integrated Children's Community Therapies Service

Children, Young people & Maternity II

Commissioning intention	
Families	• Work with Public Health and Children's Social Care to develop and implement the **"1001 days local strategy"** to better support families and children from conception to age two (Building Great Britons) • Support partners in the Healthy Start roll out and identify initiatives that will promote healthy eating and reduce overweight and obesity in children

Maternity	• **Maternity** - Whilst the CCG performance is largely in line with the national average, we will focus on community specific improvement initiatives to secure further reductions in the:
	  • Frequency of stillbirths
	  • Frequency of premature births
	  • Frequency of low birth weight babies
	  • Infant mortality
	• **Maternity** - Review proposals (environmental capacity and workforce) from BHT to address the projected birth-rate for 2020
	• Improve the experience of women requiring support from the **Early Pregnancy Units** at SMH& WGH ensuring timely access for scans across the county

Personal Health Budgets	• Explore further opportunities to extend the roll out

Continuing Healthcare

Commissioning intention	
Service improvement	• Establish clear systems to ensure timely assessment & provision of specialist equipment and consumables • Work with care homes to define the local medical support required to ensure that residents are only conveyed and admitted to hospital when their care needs are acute • Work with our Local Authority partners in delivering Service Improvements • Work with commissioners of End of Life care to clarify provision and interface with voluntary sector providers (needs re-wording – not clear what was discussed)
Market development	• Through a procurement exercise, ensure that all services are provided through contracts with clear quality and service expectations against which providers can be performance managed
Seven day working	• To better engage and support families and carers, work with acute hospital providers and CHC team, to explore the provision of assessment 7 days a week
Personal Health Budgets	• Further extend the roll out of Personal Health Budgets

Prevention

Commissioning intention	
Stay well – Live well	• Work with key stakeholders to ensure the continued roll out of our county-wide Stay Well - Live Well Programme. • Continue to develop system wide quality incentives that promote ill health prevention and health and well being
Innovation	• Continue to work proactively with the AHSN to develop innovative models of support to empower people to make positive lifestyle changes to 'stay well for longer' and 'live well' if they develop a long term condition.
Health checks and workplace wellbeing	• Improve the uptake of health checks for those with a learning disability and/or severe mental illness • Work with the Department of Work and Pensions (DWP) to facilitate health and well being at work especially for those returning after a period of of ill health
Homeless people	• Work with key stakeholders to develop a robust plan to improve the mental and physical health outcomes of those who are homeless or at risk of homelessness.

Adult Joint Care I

Commissioning intention	
Learning Disabilities	• Re-procure a specialist **Learning Disability** Health service for Bucks, ensuring that the transition is well planned and supported • Support the new provider to lead the **transformation of learning disability services** to ensure that support is more community focussed and orientated to preventing admission and enabling more timely discharge • Work with our specialist Learning Disability provider to drive forward a collaborative approach to reducing **inappropriate use of anti-psychotics** and other powerful medicines in people with Learning Disability. • Help reduce premature mortality and health inequalities faced by people with learning disabilities by proactive participation in the **Learning Disabilities Mortality Review (LeDeR) Programme**
Parity of Esteem	• Through robust provider performance management, ensure that the additional investments made in 2015/16 to drive greater **parity of esteem** deliver the intended benefits and are sustained into 2016 and beyond • Work with our mental health and learning disability providers to provide telephone **consultant advice, education and clinical support to GPs** • Work with key stakeholders and service users to develop **mental health pathways and guidance on DXS** • Work with mental health and learning disability providers to identify mechanisms for improving the **physical health** of their service users
IAPT and psychosis	• Continue to improve access to **IAPT**, achieving national access and waiting standards • Improve access to **Early Intervention in Psychosis** Service, achieving national waiting standards

Adult Joint Care II

Commissioning intention	
Service improvement	• Work with our mental health and learning disability providers to provide timely **electronic discharge summaries** • Revisit "***What Good Looks like in mental health"*** with GPs and other stakeholders • Work with appropriate clinical leads and medicines management to review depot neuroleptics LES and develop shared care protocols for monitoring patients • In response to stakeholder feedback, work with providers to improve **transitions between CAMHS and Adult Mental Health Services** • Explore further opportunities to extend the roll out of **Personal Health Budgets**
Crisis and urgent care	• Support the Health & Well-being Board in ensuring that all partners deliver their commitments under the **Mental Health Crisis** Care Concordat, providing timely access to community crisis services for both adults and older adults • Ensure that the recommendations from the evaluation of the pilot Psychiatric Liaison Service **(PIRLS**) are considered for mental health and other contracts and a future model is agreed
Carers	• Support the delivery of the Buckinghamshire **Carer's strategy**
Dementia	• Ensure timely diagnostic and support services for **dementia** are provided closer to home and that services are in place to deliver the Bucks Dementia Strategy (2015-2018)
Disabilities	• Improve outcomes for **wheelchair users** (adults and children) in line with emerging findings from the National dataset and benchmarking • Develop and implement a county-wide strategy for **Physical and Sensory Disabilities (PSD)**

Medicines Management

Commissioning intention	
Chronic Obstructive Pulmonary Disease	• Introduction of GOLD guidelines
NPT/Insulin initiation	• Direct Award review
Care Homes	• Prescribing quality – building primary care capability
Stoma	• Streamline pathway for stoma provision
Continence	• Re-commission continence service
Gender Dysphoria	• Work with NHSE to ensure a shared care pathway that supports GPs to operate within their competence whilst providing improved access for patients

Long Term Conditions

Commissioning intention	
Self Management	• Development of Care Planning to build capability in primary care to develop self-management
Diabetes pathway transformation	• Patient education • Healthcare professional education • Improved quality/patient outcomes (builds on 2014/15 step 1 work) • Improved access to care historically provided by OPD and DSN
Respiratory	• Build expertise in ACHT team

End of Life

Commissioning intention	
Capacity profiling	• Demand analysis for different types of patients across various NHS and third sector providers
Access	• Review of single point of access and need for triage service • Embedment of information and reporting flows

Planned Care I

Commissioning Intention	
PATHWAY MANAGEMENT -	Improved access to advice and guidance especially expert advice Increased use of electronic referral systems Universal use of DXS by practices with sufficient content and business value Ensure that patient information including imaging and pathology is shared appropriately around the system Ensure that GP systems are appropriate for new referral systems Better structured processes for pathway and service updates with great consistency across the CCG System agreed protocols driving appropriate Consultant to Consultant referrals

Planned Care II

Commissioning Intention	
PATHWAY MANAGEMENT – (cont'd)	Deliver culture in all settings of continuous improvement with partners and providers in the system Increased use of collaborative commissioning Ensure that there is greater patient centric management of pathways and process including self management Improved use of telehealth and telemedicine Increased understanding and linkage between Planned Care and Urgent Care Great use of Horizon Scanning information to inform best value commissioning and delivery
GASTROENTEROLOGY	Improved clinical guidance up front ensuring appropriate referrals are made into services including follow ups

Planned Care III

Commissioning Intention	
CANCER	Increased follow up adherence to screening for all types of cancer Improved 2ww attendance statistics with earlier referrals into service
WOUND CARE	Overarching review with AVCCG of Wound Care services (including leg ulcers) ensuring appropriate services and capacity is in place
GYNAECOLOGY	Smoother and more timely transition through pathway – to quickly achieve appropriate patient outcomes

Planned Care IV

Commissioning Intention	
OPTHALMOLOGY	Reduced levels of Clinical referrals – right place first time referrals Wet AMD mobile project to expand to cover the CCG area
UROLOGY	Following deep dive work with providers to improve catheterisation support
DERMATOLOGY	Put in place an improved clinical triage which means that referrals are made to the right place at the right time including use of teledermatology
IFR	Ensure that agreed process is auditable and appropriate to ensure good flow through system

Planned Care V

Commissioning Intention	
COMMUNITY SERVICES	Work closely with the Integrated Services Initiative to ensure that appropriate and visible services exist in the community and that they are easily accessible for patients across the CCG
MSK	Ensuring that deployment of the new service delivers the outcomes and the patient experience planned along with collaboration – improved pain management
NEUROLOGY	Develop Headache pathway