CCG Operational Plan

including

Commissioning Intentions

2017 - 2019

NHS Aylesbury Vale Clinical Commissioning Group
NHS Chiltern Clinical Commissioning Group

Context

- Intent to move towards **multi-year, placed planning** and delivery – our **system Intentions**
- Deliver the **Five Year Forward View** and local **Health & Wellbeing Strategy** - our **transformation agenda**
- Enhancing **care** and **quality** and ensuring **financial sustainability**
- If we do nothing our costs will exceed our funding by about **£107million** over the next four years across the Buckinghamshire health system.
- For the Bucks CCGs - Move from **two x one year** plans **to one x two year plan**

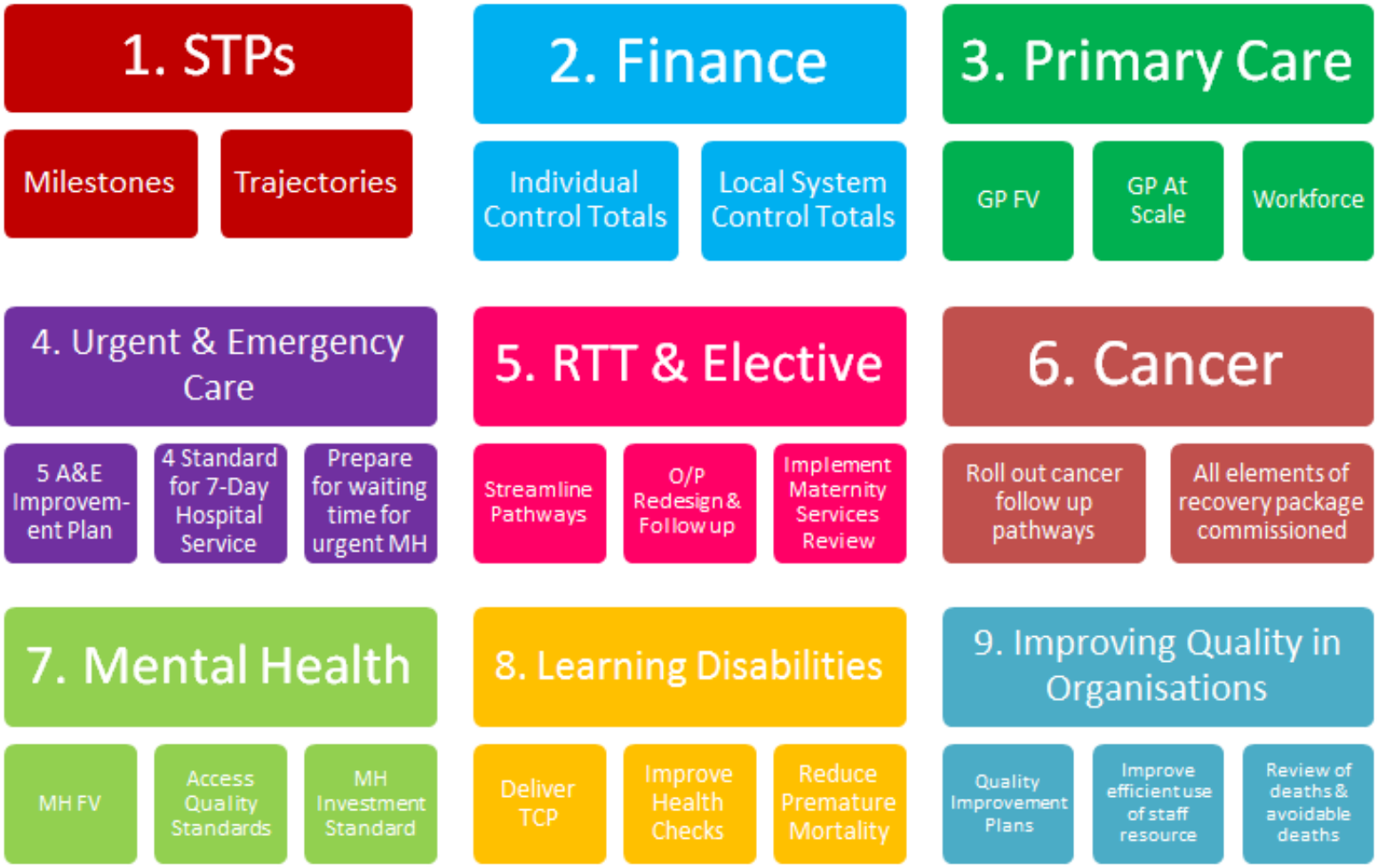
Key themes

- Delivery of **transformation** and **new models of care**, including delivery of **integrated** community based services around a **cornerstone of sustainable Primary Care**;
- Develop a **Collaborative Provider** model of local primary, mental health and secondary care;
- Develop **Care & Support Planning** with the objective to build capability in primary care;
- Commission the **iMSK** service and explore a new model of care delivery for the **Diabetes pathway**; and
- **EMIS Clinical Service system** becomes the software of choice for all primary and community services by April 2018
- The delivery of our plan will be **clinically led** through our programme boards and CCG Executive, overseen by a single Governing Body in-common.

Supported by

- Further development of **integrated commissioning** across both the NHS and with Local Authority partners, supported by lead contracting arrangements
- Opportunity to move to **outcome based models of care**
- Clinical re-design and commissioning of pathways to reflect and improve **whole system capacity and flow** including meeting 18 week RTT and national targets
- Demonstrable **workforce planning**, stability and innovation to delivery new ways of working
- **Build on planning done** previously
- Delivering our **Local Digital Roadmap** including improving digital maturity of providers and progress towards 100% referrals being made electronically

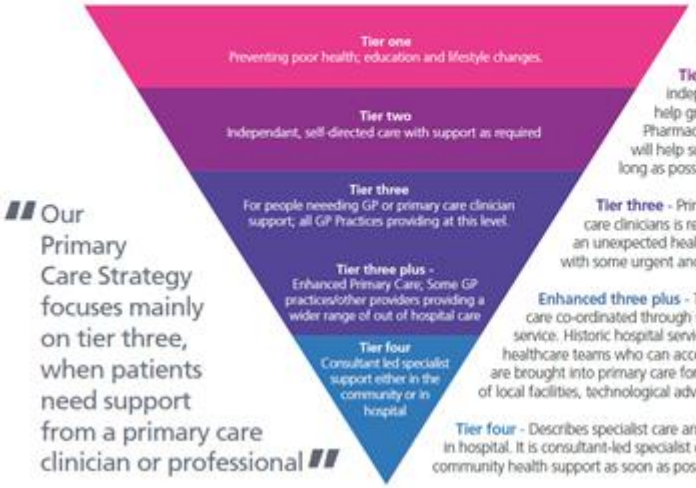
9 National Must Dos.....



Our Primary Care Strategy

'Everyone working together to provide high quality, personalised care to help keep Buckinghamshire people happy and healthy, optimising value from our collective efforts'

Tiers of care



"Our Primary Care Strategy focuses mainly on tier three, when patients need support from a primary care clinician or professional"

Tier one - Education and self support to maintain a healthy lifestyle.

Tier two - People manage most health needs independently with support such as websites, self help groups and other community professionals (e.g. Pharmacists). Planned GP appointments (see tier three) will help support people to remain independent for as long as possible.

Tier three - Primary Care support, where input from GPs or Primary care clinicians is required either to support long term condition(s) or an unexpected health concern. This is mostly planned appointments with some urgent and unexpected interventions from time to time.

Enhanced three plus - This is the real transformation, with patient centred care co-ordinated through GPs at the heart of a seamless integrated health service. Historic hospital services will be provided in local communities led by local healthcare teams who can access specialist advice as required. Exactly what services are brought into primary care for local delivery is subject to factors such as availability of local facilities, technological advances and value for money.

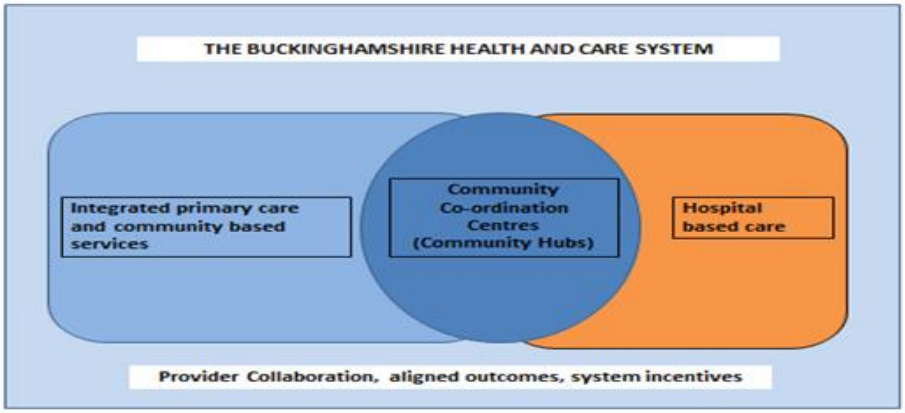
Tier four - Describes specialist care and advice, either in community-based setting or in hospital. It is consultant-led specialist care that aims to return the patient back to their community health support as soon as possible.

Next steps in delivering our Primary Care Strategy

- Improve **recruitment and retention** into general practice including through establishing a Community Education Provider Network
- Implement changes to improve management of **primary care workload** including through integrated community teams, models of practices working together and exploring a Bucks GP chamber
- Review current **estates and technology** – part of the One Public Estates work
- Commission **new ways of working** and extended GP appointments into the weekend / evening

Integrating the health & care delivery system

- **Develop the provider model** including new incentives for providers to work collaboratively through networked arrangements, building on the work to finalise a **Multi-speciality community provider** (MCP) in Buckingham
- Develop **Community Hubs** across our localities
- Develop further our **locality based programmes** of work including supporting care homes and programmes such as Community dementia support



Continue to deliver our existing Mental Health Strategy

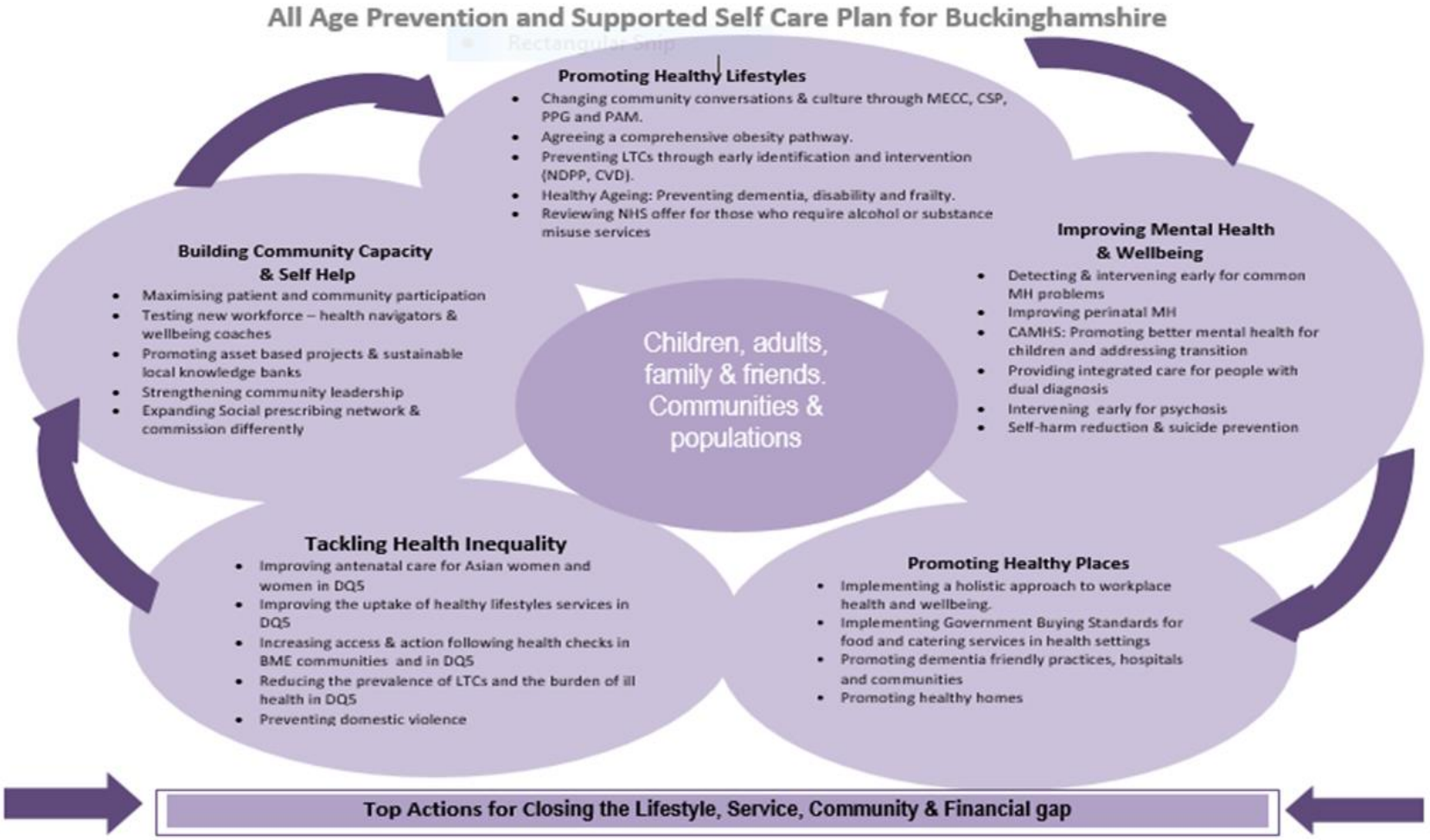
Priority	Key Action
Priority 1: Improving mental wellbeing, reducing stigma and moving to achieving parity for mental health	• Develop support and treatment for those with **long term physical conditions** building on the **IAPT (Improving Access to Psychological Therapies)** programme. • Increasing access **to screening and physical health interventions** to those with Serious Mental Illness • Develop a **mental health directory** working with local third sector organisations and people affected by mental health • **Utilise the Mental Health Partnership Board** to enable partner agencies to work together to make best use of the resources available
Priority 2: Intervening early with support in primary and community care	• **Further develop IAPT services** to ensure at least 19% of people with common mental health conditions access psychological therapies by 2018/19, **utilising our status as an Integrated IAPT pathfinder site**. • Expand our '**ESA**' national pilot and consider ways to ensure individual placement support for those with SMI • **Review pathway for eating disorders across children and adult services** to ensure timely access, earlier intervention and reduction in admissions. • **Review the new NICE compliant Perinatal Mental Health** service to enable further development • Implement changes to the all age pathway for people with **autism or autistic traits** and their carers
Priority 3: Managing mental ill-health and moving to recovery	• Continue to increase access to EIP to ensure 53% are treated in 2 weeks by 2018/19 • Audit and develop plans to ensure sufficient capacity in the CAHMS outreach service and CRHTTs to maintain 24/7 urgent and emergency response times • Review data on Out of Area admissions to establish a plan to reduce the numbers placed out of area • Improved consistency of collection and reporting of patient reported outcomes
Priority 4; Service user inclusion and involvement	• Further develop the Recovery College , launched in September 2016
Priority 5: Embedding the right to choice in mental health services	• **Publicise** patients' rights to choice • **Support GPs** to understand eligibility for choice • Ensure **transparency** from providers • Expand use of **ERS to Mental Health**

In addition we will continue with the implementation of our joint Buckinghamshire Dementia Strategy

Continue the Transforming Care Partnership plan

Priority	Key Action
Priority 1: Develop community services to support people earlier to prevent or delay admissions to inpatient settings	• Work with Criminal Justice Service to **reduce the numbers into inpatient beds** from the **forensic** pathway
Priority 2: Identify more people with Learning Disabilities and provide good quality health checks and proactively drive Care and Treatment Reviews	• Roll out **CTRs across mental health and CAMHS services**
Priority 3: Improve the transition from C&YP to Adult Services	• Deliver the **improvements** identified **in transition** from CAMHS to Adult Mental Health Services and Learning Disability services
Priority 4: Develop pathways for people with autism and their carers	• Develop a programme to **increase awareness** and understanding of autism • Develop a clear, consistent **pathway for diagnosis** • **Improve access** to services and support • Helping adults with autism into **work** • Create **commissioning framework** to enable local partners to develop relevant services

Promoting self care and a radical step change in prevention



Promoting self care and a radical step change in prevention

- Enable people with long term conditions and disabilities to have greater choice, flexibility and control over their health care and how they receive it through increased offers and use of **Personal Health Budgets**
- Implement the **Live Well Stay Well** strategy and action plan
- Deliver a clear and integrated pathway for **obesity** including an intensive lifestyle intervention programme
- Workplace wellbeing - Extend current annual **Health and Wellbeing programme** to both CCGs
- Continue roll out of **Care & Support Planning**

Reforming urgent and emergency care

- Delivering the recommendations of the **Urgent and Emergency care review** through the **Thames Valley network**
- Deliver the system plan collectively through the **A&E delivery board**
- Further develop an **Integrated Urgent Care Service** including arrangements for NHS111, Out of Hours and MIIU
- Define consistent **clinical pathways** for urgent care and reduce clinical variation with an increased focus on **paediatric urgent care**

Continue work on planned health care

- Using benchmarking e.g. the Right Care Commissioning for Value packs and Atlas of Variation we have identified priorities including:
  - **Diabetes** - Progress the Diabetes Transformation Programme including quality improvement, at scale prevention programme, different model of care from providers
  - **Cancer** – Finalise cancer strategy and move to implementation including prevention, improved rates of early diagnosis, uptake of screening programmes, efficient treatment pathways are available
  - **MSK** – Launch the new integrated service
  - **Cardiovascular** – improve healthy lifestyles, improve identification of those at risk of CVD and develop a Heart Failure Lounge.
  - **Maternity** – Develop plans to respond to the national maternity review – Better Births, building on the work led by the Thames Valley Strategic Clinical Network and local initiatives on infant mortality and low birth weight babies

Develop our End of Life pathways

- Build on **Advanced Care Planning** approach
- Work with all relevant providers to understand current **capacity** for EoL care provision and what changes are required to enable specific EoL care to start sooner
- Develop **primary and community support** through our Primary Care Strategy “Tier 3+”
- Roll out of **electronically accessible shared care records** as a key enabler of delivery

Deliver our Local Digital Plan

We have developed a system wide Local Digital Roadmap. We have already begun delivering this but, subject to funding, our priorities for the next two years include:

- **Personalised Health and Care** – including roll out of EMIS Clinical services to support integrated working across primary and community based services. Patient and citizens empowered to support their own health and care lifestyle choices through diverse digital technologies, including access to their own records.
- **Paperless** – Plan for move from N3 to Health & Social Care Network in 2017/18 and increased use of electronically referring and discharging between providers
- **Shared care records** – deliver Phase 2 of the My Care Record programme including information sharing across health and social care. Implement the new Child Protection Information Sharing System.
- **Increase Digital Capability and maturity** across the health and care system
- **Digitally enabled new ways of working** – including support for primary care e.g. electronic consultations and practices working together across localities, pilots such as Airedale and DLS

We are bringing the three LDRs in the STP footprint together to accelerated adoption and share best practice.

Deliver our Quality Strategy

We have developed the CCG Quality Strategy to include a Quality Assurance Framework for Primary Care, we will:

- Target **specific improvements** for quality, safety and patient experience
- Review progress made regarding **reducing avoidable harm and avoidable mortality**
- Build on the establishment of a **joint approach to quality and performance** to harmonise our quality assurance systems
- Promote **strong clinical leadership** and safer staffing and workforce development
- Embed the revised **Quality Strategy with Primary Care and Care Homes** to ensure effective monitoring of Quality in Community and Primary Care
- Establish effective **engagement mechanisms with service users** to gain feedback to improve services and support commissioning intentions.

Glossary

A&E	Accident & Emergency
C&YP	Children & Young People
CAMHS	Child and Adolescent Mental Health Service
CRHTTs	Crisis Resolution & Home Treatment Team
CSP	Care & Support Planning
CTRs	Care and Treatment Review
CVD	Cardiovascular Disease
DQS	Data Quality System
EIP	Early Intervention in Psychosis
EMIS	Education Management & Information System
EOL	End of Life
ERS	E-referrals System
ESA	Employment & support allowance
GP FV	General Practice Forward View
IAPT	Improving Access to Psychological Therapies
iMSK	Integrated Musculoskeletal

LDR	Local Digital Roadmap
LTCs	Long Term Conditions
MCP	Multi-speciality Community Provider
MECC	Making Every Contact Count
MH	Mental Health
MH FV	Mental Health Forward View
MIIU	Minor Illnesses & Injuries Unit
MSK	Musculoskeletal
NDPP	National Diabetes Prevention Programme
NICE	National Institute of Clinical Excellence
PAM	Patient activation measure
PPG	Patient Participation Groups
RTT	Referral to Treatment
SMI	Serious Mental Illness
STPs	Sustainability & Transformation Plans
TCP	Transforming Care Plan