NHS
West Cheshire
Clinical Commissioning Group

Delivery of the West Cheshire Way

Commissioning Intentions – 2017-19

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WEST CHESHIRE CCG

DELIVERING THE WEST CHESHIRE WAY COMMISSIONING INTENTIONS 2017-19 2018/19 Update

BACKGROUND

1. Our commissioning intentions should be considered in conjunction with the following documents previously published by West Cheshire Clinical Commissioning Group:

    - West Cheshire Clinical Commissioning Group Operational Plan 2017-19
    - Children and Young People's Mental Health and Wellbeing Transformation Plan 2015-2020
    - West Cheshire Clinical Commissioning Group Five Year Commissioning Strategy 2014 - 2019
    - Financial Recovery Plan 2017/18 and 'Our Savings Plan 2017/18'

2. The intentions as set out in this paper will form the basis of a refresh of the Clinical Commissioning Group Operating Plan that will be used to inform local business planning as well as for sharing at a regional level as required. These intentions are informed by national strategic policy and guidance including the NHS Five Year Forward View and associated documents, as well as national guidance relating to specific clinical thematic areas, national and regional best practice and local intelligence including clinical and patient feedback.

STRATEGIC DIRECTION – INTEGRATED CARE

3. The challenges nationally (of a growing elderly population, rapidly developing technology and higher incidence of long term conditions), have been set out in the Five Year Forward View and other national planning guidance as well as through the development of the West Cheshire Way, Financial Recovery Plan and our Savings Plan which indicate that we must radically reshape the future of care delivery in order to be able to offer local people a sustainable effective care model.

4. Therefore, the leaders of health and social care in West Cheshire are committed to creating a single organisation in the longer term that involves providers working together to meet the needs of local people. These providers will be responsible for a budget allocated by the commissioner to deliver a range of services to that population. The provider will work under a contact that specifies the outcomes and other objectives to be achieved within a given budget over a number of years.

5. This approach supports the direction of wider strategic change, as Sustainability and Transformation Programmes form at regional level to take greater responsibility for strategic commissioning, planning and assurance.

6. During 2017/18 significant progress has been made in moving forward our West Cheshire ambitions for integrated care. Our plan to join-up care delivery across West Cheshire has been developed locally by clinicians, practitioners and the experiences of local people. A Strategic Outline Case has been developed which, supported by system leaders, considers the benefits of integrated care and the case to invest in the development of an Outline Business Case (as part of 'phase 3' of our integrated care development). The Strategic Outline Case details the case for change, how these benefits will be achieved and details the services we initially expect to be included as we move towards a whole system integrated care model.

7. System leaders have agreed that given the financial and resource constraints on the health and social care system that it is important to maintain progress but with a more limited set of priorities to achieve quick wins. It is therefore imperative that we fast track elements of the service redesign to ensure quality improvement and system financial stability by 2020 is achieved (it is acknowledged that without a significant system change the £65 million financial gap forecast by 2020 will not be bridged).

8. The prioritisation process for phase three builds on the work completed in the strategic outline case and associated compendium, plus the scoping document for phase three.

9. Further work is required to assess the financial and performance impact of the priorities. The financial modelling completed by the finance work stream will be used to calculate early savings and an assessment of investment.

10. Table 1 below details the priorities we are seeking to address through integrated care;

Table 1 - priorities we are seeking to address through integrated care

The challenge	The current state	Why we need to change
Population health and economic challenges facing West Cheshire.	The system is currently struggling to adapt to the main health problems in West Cheshire: • *Ageing population*:18% of the population in West Cheshire are over 65 years old (a higher percentage than the north west and nationally), and a 19% increase in the number of over 85 year olds over the next five years is projected and this is expected to increase to 2030. A significant percentage of the population is also retired (this is above the England and North West average. The population has a relatively low number of individuals within the 16-64 age bracket. The number of people within the 0-39 age bracket is significantly below the North West and England average • *Health inequalities*: There are a number of elderly living at home suffering from greater deprivation – these people are mainly in the rural (and hence more isolated) areas of West Cheshire • *High key risk factors for ill health*: Overall the health of the population of West Cheshire compares favourably to the North West and England average. Fitness levels of the 16-64 age group compare favourably with the national average though there are high risk factors indicated through higher rates of liver cancer (both sexes). Risk factors relate however to frailty and conditions associated with frailty given the relative high age of the population and the expected rise in the over 85 age group • *Long term conditions*: Around 12% of people aged over 65 in West Cheshire have three or more long-term conditions, and this will increase as the population ages. The prevalence of dementia is also expected to increase over the next 10 years (over 75 age group).	These challenges will only exacerbate as the population ages as a proportion of the overall population, and will lead to further health issues and significant demand on the system. We need to tackle these issues head on, focusing on prevention, including community engagement and participation and intervening early to slow the growth of these issues.
Too many people in West Cheshire are ending up in hospital and bed-based settings rather than being cared for in their home or the community.	The level of people being admitted to bed based care is symptomatic of: • **Poor risk stratification**: We do not fully identify and target those at risk or with a rising risk of health and/or social care needs though primary care risk stratification indicates the issues associated with ageing (CVD, and particularly COPD. Depression is also a factor in the 55-65 and 80-84 age group. • **A focus on reactive rather than proactive services:** We wait for people to develop poor health and do not emphasise prevention and early intervention. • **Poor signposting**: There is poor signposting of people to services that can improve their wellbeing, resulting in too many people ending up in hospital beds.	Risk stratification in primary care again indicates that the highest group are the over 75s. Utilisation of bed based care for this population is highly expensive, and high usage is indicative of a population with escalating health issues that are currently not being address sufficiently within a community setting. We therefore need to focus on shifting care into the community and home to improve population outcomes and reduce the financial pressure on the system. We also need to understand the services
Health and social care services are fragmented and are not designed to collectively serve the population.	Our health and social care organisations are fragmented and do not always provide joined up care. We know, for example, that people are not receiving holistic needs assessments which focus on what matter to people, meaning that despite good intentions and best efforts, care is not always suited to the needs and it is too commonly siloed, duplicated and disjointed.	We often focus on what we can do for our individual organisations and are unable to call on the expertise of the entire system to deliver optimal care.
Resources are sparse and not always allocated in the best way.	We agreed that there are insufficient resources in the system, and that the resources we have are not always allocated to the right place at the right time.	Our people cannot always access the right care, affecting the service they receive. Also, as the funding gap increases, resources will become more sparse and the inefficiency of resource allocation will be magnified unless we change.

11. We have worked in partnership to develop design principles for integrated care. A key challenge is to empower people to take responsibility for their wellness or self-care and to establish more effective health optimisation and prevention services. We will be able to challenge the behaviour of staff and people, supporting effective risk management with shared decision-making at the heart of care. Being in a bed in a hospital should be the last alternative, and if people are at higher risk, we will seek other choices. Resources will be targeted to ensure that community-based support addresses the needs of individuals more effectively.

12. Senior Leaders have agreed that given the financial and resource constraints on the health and social care system in the immediate term, there is a need to focus initially on quick wins. It is, therefore, imperative that we fast track elements of the service redesign to ensure that quality improvement and system financial stability by 2020 is achieved (it is acknowledged that without a significant system change the £65 million financial gap forecast by 2020 will not be bridged).

13. The prioritisation process for phase three builds on the work completed in the strategic outline case and associated compendium, plus the scoping document for phase three.

14. Further work is required to assess the financial and performance impact. The financial modelling completed by the finance work stream will be used to calculate early savings and an assessment of investment. Fast track elements of the service redesign and resource alignment work will be undertaken to ensure that quality improvement and system financial stability by 2020 is realised.

15. Table 2 below describes the priorities to be taken forward within phase three;

Table 2 - describes the priorities to be taken forward within phase three

Priority	Priority rating 1 = High 5= Low	Action	Outcome (including system improvement targets, forecast savings and investment)	
			Performance	Savings and investment/shift of investment £
Develop and deliver Integrated Teams across the West Cheshire Health and Social Care system	1	The health and social care economy will work together review the current operation of Integrated Teams and develop and agreed framework for delivery of these teams across the whole of West Cheshire		
Develop an agreed risk stratification tool across the West Cheshire Health and Social Care economy.	2	Develop the work already completed to date (i.e. the baseline assessment of systems and utilisation effectiveness). The Clinical and Social Care Transformation Group will consider and refine both the necessary algorithms to ensure that people are effectively risk stratified into 4 groups – ie Very high risk, moderate and rising risk, low risk and healthy and well.		
Develop the digital and community front door specification and delivery plan in detail with associated IT, finance and workforce implications.	2	Emphasis on both the detailed development and implementation of the Digital and Community Front Door. This will include elements of the self serve/assisted assessment, development of a single point of access (including a directory services that supports signposting/redirection).		
Scope and implement a respiratory care pathway that support the principles as set out in the Strategic Outline Case	2	Clinicians, practitioners and managers will work together to develop a care pathway for patients focusing on those with respiratory conditions. This work will support the work to date completed in phase 1&2 (care pathway)		
Scope and implement a frailty and elderly pathway addressing the key target group as defined in the SOC and supporting compendium	2	Utilising the definition of frailty as set out in the compendium develop an effective frail and elderly care pathway that delivery the right interventions for the cohort of people incorporating care navigation and neighbourhood team support		
Complete a baseline assessment of IT systems that support the delivery of care pathways and also an assessment of predictive analytics capability and performance monitoring across the Health and Social Care Economy.	3	A baseline assessment of all clinical and monitoring systems will be completed including an assessment of their current effectiveness. This work is aligned to the development of the risk stratification work. Systems evaluation will also include how effective the health and social care economy is at predicative analytics (specifically population forecasting) and performance monitoring and improvement (including the consistency of outcome development across pathways of care)		
Develop a supporting workforce delivery plan that supports the delivery of the digital and community front door. This plan will also reflect the changes required to implement the new respiratory and frail and elderly pathway	3	A comprehensive and costed health and social care workforce plan will be presented that reflects the skills and experience required to deliver and maintain the new models of care as required by the digital and community front and the new care pathways.		
Develop a change roadmap for primary and social care aligned to the workforce delivery plan, the requirement of the digital and community front door and the new care pathways.	1	A roadmap will be presented that sets out the delivery requirements for primary and social care including potential investments and cost shifts		
Develop a communications and PR delivery plan for integrated care across West Cheshire that ties to the development of self support, directory of services and signposting. This delivery plan will include tactical as well as strategic elements of HR.	3	Communications and PR delivery plan in place and implemented – this plan to be developed across health and social care. This delivery plan will set out the PR approach to support the successful communication and delivery of integrated care across West Cheshire		
Governance arrangements for phase three delivery to be developed and agreed. This includes a review of the clinical cabinet and delivery assurance and finalising the Memorandum of Understanding. Programme support and governance will also be development further in light of the resource requirements to support delivery of Phase 3	1	Revised delivery and transformational governance to be agreed and implemented – this will focus on supporting the delivery of Phase 3 and finalise the Memorandum of Understanding		

SUSTAINABILITY AND TRANSFORMATION PLAN ALIGNMENT

16. As the newly appointed Executive Chair of the Cheshire & Merseyside Sustainability and Transformation Plan, Andrew Gibson has written to all Clinical Commissioning Groups acknowledging the genuine desire to refresh and refocus the Sustainability and Transformation Plan and to deliver some real change across the patch, renamed as 'NHS Cheshire & Merseyside'.

17. There is also an emerging desire from NHS England and NHS Improvement for the Sustainability and Transformation Plan to become the local 'system manager' (progressively taking on many of the functions currently undertaken by local NHS England/Improvement).

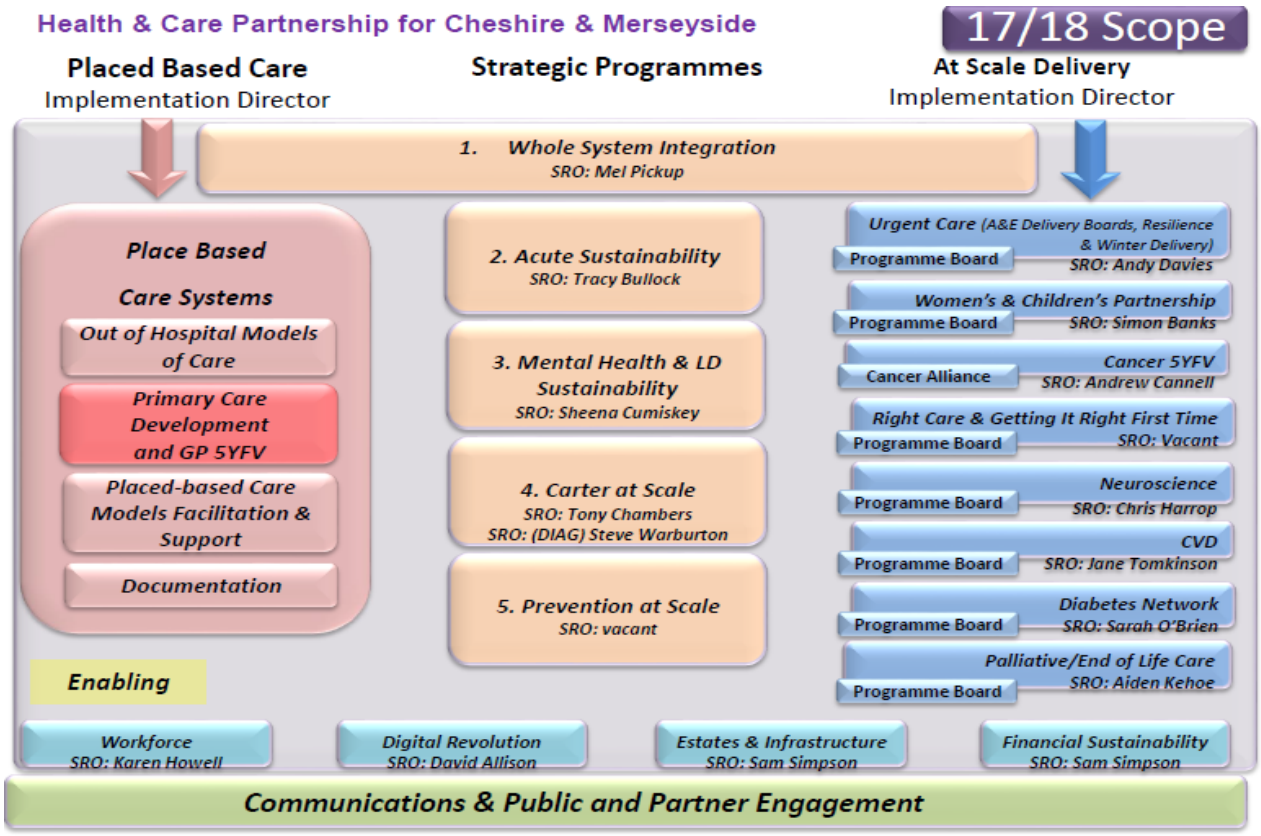
18. As System Manager, it will hold organisations and partnerships to account for delivery, especially in the development and implementation of integrated care, with particular emphasis on working with Councils and the third sector.

19. In addition NHS Cheshire & Merseyside will lead on matters that are better undertaken at scale. These may include acute sector sustainability, commissioning at scale, workforce planning, system development and clinical networks. The main focus for change and delivery however will be through the development of 'Place-based Care', where all care, direct and indirect, NHS and non NHS, for a defined population will be integrated and managed through a single accountable approach.

20. Initially, it is proposed that these placed based communities be aligned to each Borough/Council boundary, recognising that there may be sound arguments for some adjustments now and in the future. NHS Cheshire & Merseyside will support places to deliver at pace but it will be for each locality to determine the precise nature of its integration and its relationships as long as Primary Care and local authorities are seen to be central to, and full participants in, the approach. Equally, local arrangements which ensure robust engagement with all stakeholders at every stage are a core expectation.

21. NHS Cheshire & Merseyside will be the System Manager for health services within Cheshire and Merseyside. It will progressively be involved in all NHS decisions affecting the area, either directly or as co-partner. For example, this would include such issues as winter planning, local performance, service reconfigurations and bids for revenue/capital funding. The organisational structure is shown in figure 3 below.

Figure 3 - NHS Cheshire & Merseyside Programme priorities



FINANCIAL RECOVERY PLAN

22. We have agreed a financial recovery plan with NHS England that, if successfully delivered, will meet the following trajectories:

- Delivery of a 0.5% surplus as at the end of 2017/18[1].
- Return to underlying recurrent balance during 2018/19.
- Delivery of NHS England business rules by the end of 2019/20.

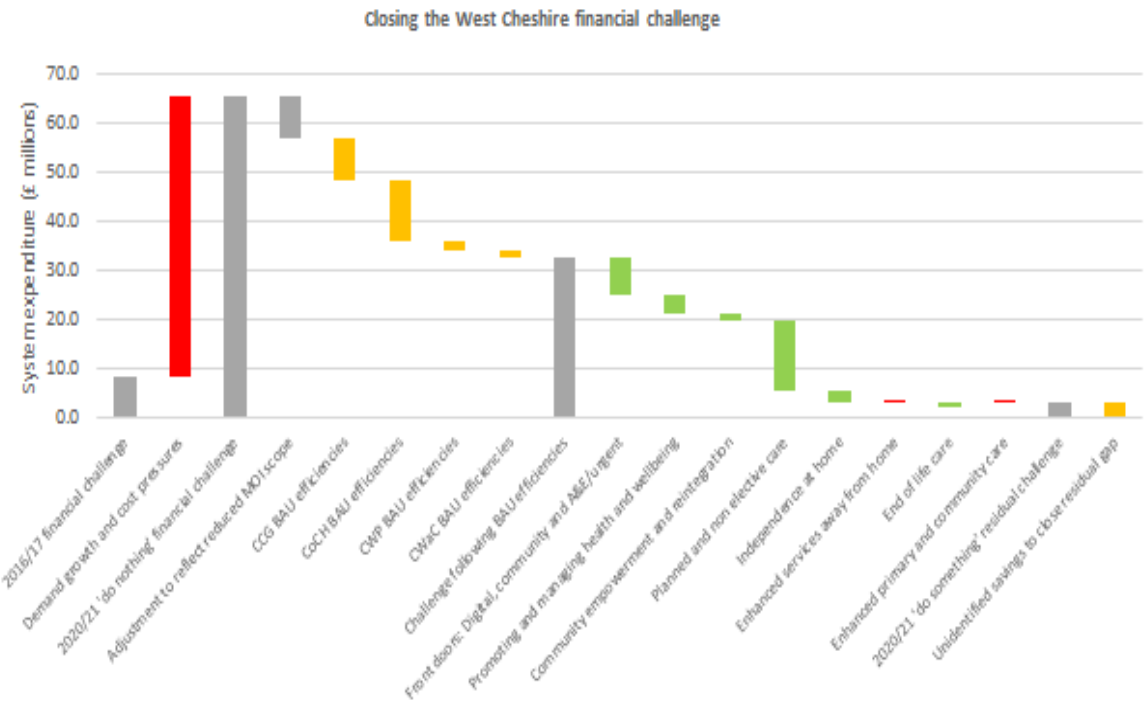
23. As part of the development of integrated care in West Cheshire, we have been working on a joint finance and activity model forecasting the economy wide financial outlook up to the year-end 2010/21. A detailed explanation of the work undertaken to date has been shared with all partners and is integral to our agreed strategic outline case.

24. We know that if we do not integrate care we will have a financial gap of approximately £65 million; described as our 'do nothing' financial challenge. We have modelled the potential impact from our proposed integrated care target operating model and believe that we can reduce the financial gap significantly; as demonstrated by the figure 4 below.

[1] *We are currently forecasting year-end financial balance. However, in line with NHS England guidance, we are holding a non-recurrent reserve of £1.672 million which, when released, will deliver a 0.5% surplus.*

25. Our 2018/19 commissioning intentions support the delivery of the proposed efficiencies outlined in our strategic outline case.

Figure 4 – closing the West Cheshire Financial Gap



COMMISSIONING INTENTIONS

26. Our approach in West Cheshire is to work collectively, as a system, to deliver our aspiration for integrated care.

27. The Clinical Commissioning Group will work within the intention that our key providers will remain on a 'block contract' arrangement. In addition, with other commissioners, we will move away from activity based currencies to alternative arrangements, that incentivise improved outcomes and service integration.

28. We will review our Estates and ICT strategies and delivery plan to ensure optimisation of our investments (in line with the developing model of care) and maintenance of expenditure, whilst maximising the utilisation of our properties and technology.

29. In addition to the priorities outlined above, our delivery programmes are focussed on improving effectiveness, efficiency and clinical outcomes within Urgent Care, Planned Care, Primary Care, Medicines Management, Starting Well, Continuing Health Care & Complex Care, Mental Health & Learning Disabilities, forming the basis of our financial recovery plan.

30. We will look to build on the system-wide working continued in 2017/18, which was supported by the inclusion of a 'Service Development and Improvement Plan' within the contracts of our two main providers to deliver our intentions.

31. We will therefore look for our commissioning intentions to form the basis of a single West Cheshire-wide improvement plan in 2018/19, that will be supported by an increasingly integrated management team as well as integrated service delivery through the afore mentioned integrated care development work.

32. Our programme commissioning intentions are informed by national guidance particularly the NHS Five Year Forward View (and related documents) as well as national/regional best practice and local data analysis including patient feedback.

33. Good quality services should produce good outcomes and ensuring we have an effective way of measuring this is critical to the success of our ambitions. Throughout 2017/19 we will continue to develop our quality assurance frameworks, drawing on the experience of the wider system partnership.

34. The sections below set out the refreshed commissioning priorities for 2018/19 within our programme areas:

Urgent care

35. There are still several Single Points of Access within the West Cheshire Urgent Care System. There are commissioning opportunities working with system partners to develop an integrated digital Single Point of Access, as part of our work to develop a single digital front door, for both patients and clinicians. This may involve decommissioning current arrangements and entering into integrated commissioning arrangements across West Cheshire.

36. The Urgent Treatment Centre was relocated in its new design to the front of the Countess of Chester Hospital incorporating GP Out of hours Service (OOH). This service will be developed further in order that all NHS England core requirements for service delivery are achieved by the end of 2019, including direct booking via 111. The ambition is for a digital front and back door at the acute trust with tele tracking moving through to discharges, as it is rolled out, which should positively impact discharge management and in turn Delayed Transfers of Care . The Urgent Treatment Centre demand profiling will be reviewed, in light of the increasing number of attendances across West Cheshire and to explore whether a second base is needed in the Ellesmere Port area.

37. Furthermore, we will work with Chester West and Chester Council, to develop a system-wide understanding of bed capacity.

38. There continues to be over performance of non-elective admissions related to long term respiratory illnesses and ambulatory care sensitive respiratory conditions. To this end there will be a review of service provision associated with these conditions and service redesign to prevent deterioration leading to crises wherever possible.

39. In 2016/17 we have undertaken a review of our falls service; discussions will continue to take place with the intention to commission, with the local authority colleagues and Vale Royal Clinical Commissioning Group, a more effective falls prevention and intervention service across the health and care economy. Further falls interventions and pathway development in the community will be undertaken in 2018/19.

40. We will continue to review pathways of care for people with mental health needs and learning disabilities in crisis to ensure parity of esteem and enable people to be cared for in the place that best meets there need, minimising the need for treatment of any individual in a police cell.

Intermediate Care

41. The Intermediate care review commenced in summer 2017. The first phase was implemented in October 2017. The second phase involves developing integrated medical provision for the whole of Intermediate care capacity with potential for procurement to support this before the end of 2018. This will involve reviewing the commissioning arrangements for the Hospital at Home Service.

42. We intend to focus on improving the admission avoidance potential with the care home sector, which will incorporate cross system working with all partners to deliver improved support for care home workers and improved care to patients. To this end there will be a focus on high impact improvement schemes across care homes supporting both 4hr access target and delayed transfer of care targets and improved system working through the development of the Trusted Assessor model.

43. We are entering year 2 of the Paramedic Emergency Service (PES) contract. West Cheshire Clinical Commissioning Group will continue to provide commissioning input on a collaborative basis.

NHS 111 and Ambulance services

44. We expect to see full implementation of the Ambulance Response Programme in 2018/19.

45. West Cheshire Clinical Commissioning Group will continue to provide commissioning input in relation to NHS 111 on a collaborative basis with all other North West Clinical Commissioning Groups. Key commitments for 2018-19 are the rapid development of the Clinical Advisory Service to broaden the selection of clinical services available via the Clinical Commissioning Groups Directory of Services in order to avoid all unnecessary referrals to A&E. West Cheshire Clinical Commissioning Group's Directory of Services is to be further expanded to include community pharmacists, dentists, opticians and Mental Health among other local services. West Cheshire Clinical Commissioning Group will continue to support the further development of the county-wide Directory of Services team hosted by the Clinical Commissioning Group and bring it into line with equivalent Directory of Services teams across the North West.

46. We will work with service providers to take advantage of the development of direct booking from NHS 111 into clinical services. Direct booking is a key objective of the Integrated Urgent Care specification.

47. In 2018-19 will see the introduction of NHS 111 Online. This will be a wholly new service based on the existing NHS Pathways algorithm. West Cheshire will participate in the collaborative commissioning of NHS111 Online roll-out during the 2018-19 financial year, which is in line with our local ambition to develop a single digital 'front door' to access services in West Cheshire.

48. West Cheshire Clinical Commissioning Group participates in the collaborative commissioning of West Midlands Ambulance Service, as provider of Non-emergency patient transport services. The Clinical Commissioning Group undertakes to participate in the County-wide Governance group where performance is reviewed in a county-wide setting. West Midlands Ambulance Service is participating in the 'Every Contact Counts' initiative that emphasises the health prevention role when meeting patients face-to-face. The Clinical Commissioning Group will continue to encourage appropriate use of patient transport to facilitate timely discharges from hospital through advice and support to GP practices.

End of Life

49. The community consultant post to support improved end of life care will be in post by April 2018 to support our strategic intention to provide 24/7 end of life care.

50. An end of life training plan will be devised for clinicians across West Cheshire.

51. We will continue to implement the End of Life strategy to improve care for the West Cheshire population including a strong focus on effective and integrated end of life care planning.

Planned Care (including Long Term Conditions)

52. We are continuing to deliver against our ambition to see care for Long Term Conditions primarily delivered in the community setting. In 2018/19, we want to support primary and secondary care clinicians, to work together to develop appropriate pathways of care that include;

    a. We will commission one well-being and self-care management service which offers advice, guidance and information along with one to one peer support and self-care management courses. This is a redesigned service and will replace what was previously three separate services. This will enhance service delivery and achieve better patient outcomes. Providers are expected to be aware of the self-care options/interventions and appropriately signpost patients to these services. In addition our NHS Trusts will be screening all patients within their setting and offering brief advice and referral for patients who smoke or have high alcohol consumption.

    b. Patient Activation Measures; as well as addressing prevention, the Clinical Commissioning Group recognises that the way to reduce the demands of Long Term Condition treatment on healthcare is to; empower patients to manage their condition more effectively, treat the person holistically and to provide services that engage the patient in effective action planning. The Patient Activation Measures tool will support appropriate tailoring of interventions to enhance positive outcomes and provide a measurement of the effectiveness of interventions. Engagement has taken place with GP practices to identify those that are keen to be involved in the project and a number have signed up, however it is expected that in 2018/19 we will continue to roll the tool out further.

    c. Diabetes: Diabetes Essentials (a structured patient education programme) will continue to be commissioned in 2018/19 and patients that successfully complete this course will be offered a place on the National Diabetes Prevention Programme. The National Diabetes Prevention Programme has been commissioned to reduce the growing numbers of patients that

develop Type 2 diabetes and will continue in 2018/19. We will ensure more patients successfully complete the course and reduce their risk of developing diabetes. Work has also been undertaken, funded by NHS England, to enable diabetes pathway changes with a focus upon improving inpatient care; including medication accuracy and patient self-care. This work will reduce repeat admissions and reduce the length of time a patient is required to stay in hospital.

d. Cardiovascular Disease conditions including: Hypertension, Atrial Fibrillation, Coronary Heart Disease and Heart Failure will continue to be reviewed and pathways redesigned to provide improvements in the detection and treatment of these conditions. This includes the continuation of work that has been ongoing with Public Health (including CHAMPs) and the Innovation Agency, to introduce new ways of working to identify those at risk of Hypertension and Atrial Fibrillation. The opportunistic Atrial Fibrillation testing in the community will continue to be carried out by Cheshire and Merseyside Fire Service.

e. Respiratory – a tremendous amount of work has taken place in relation to COPD and Asthma, including pathway redesign and a shift to provision in the community. Work will continue into 2018/19 to address high numbers of patients with pneumonia, to redesign the Pulmonary Rehabilitation service and to update the pathway/contract with the Home Oxygen service. There will also be close working with urgent care to address the high number of non-elective admissions for respiratory patients, as referenced earlier.

f. Cancer - the Clinical Commissioning Group will continue to work closely with secondary care to meet the national targets for the diagnosis and treatment of cancer conditions. We will continue to focus on streamlining pathways to ensure more rapid access to care for those that need it, building on the work done across Cheshire & Merseyside through the Cancer Alliance. During 2018/19 we will specifically focus on:

   - Urology – implementation of a haematuria pathway, implementation of a prostate cancer/ post prostate pathway.
   - Head and Neck – streamline current pathway.
   - Lower GI - streamline current pathway.

   Work will also continue on establishing clear cancer follow up pathways taking a person-centred approach to care. The electronic health needs assessment tool (eHNA) will be used to provide support for patients who are living with and beyond a diagnosis of cancer and have health and wellbeing concerns. This will ensure people affected by cancer know what they can do to help themselves and who else can help them. Macmillan

wellbeing co-ordinators will be integrated with existing community services to provide cancer specific holistic needs assessments and signposting to third sector provision as well as a direct referral route to secondary care.

g. We will continue to commission the Primary Care early identification programme for domestic abuse. This preventative approach sees sufferers of domestic abuse supported earlier to reduce harm and health deterioration. Following on from its early success in previous years the Clinical Commissioning Group plan to continue to jointly commission this with the local authority for 2018/19.

53. Neighbourhood care - This project was pump primed by NHS England to test the concept of 'self-managing' integrated Health and Social Care teams, that have autonomy to provide the most appropriate patient-centred care that meets the needs of the patients within their community. This includes greater patient empowerment to manage their own conditions. This is taking place within the rural community of Malpas/Broxton. Once the success of the pilot has been evaluated, the effective elements will be rolled out across West Cheshire during 2018/19, in line with the integrated care priorities referenced above.

54. Following the successful roll out of the referral support mechanisms, we intend to ensure that all referrers continue to make effective use of the pathway portal to support their decision making, that all referrals (including all age) are electronic and are triaged appropriately prior to being seen in secondary care and that the Commissioning policy is adhered to, in supporting appropriate management of demand. This requires ongoing support of specialists to continue to refine the electronic pathways/referral templates and triaging referrals to ensure patients get to the right place first time.

55. Pathway redesign, where diagnostic requests are involved, is required to aid service improvements such as ordering imaging at the point of a referral into secondary care, which will help support faster access to treatment. Guidelines will be produced to ensure that tests/scans are only requested where they have a proven record of aiding diagnosis. This will reduce the likelihood of patients undergoing unnecessary tests (and reduces the risks around exposure to radiation).

56. We will continue to use best practice data and intelligence including Right care to ensure delivery of the best value and highest quality outcomes across our pathways. As a result we have prioritised the following pathways;

    a. Ear, nose and throat; we are looking to redesign the provision of services to ensure improved service delivery including best practice prescribing and a shift of provision for some elements into the community (e.g. audiology).

b. Gastroenterology; there are a number of pathways that are being reviewed and redesigned to provide a better outcome for patients and for more care to be delivered closer to home by a wider skill mix of clinicians.

c. The Musculoskeletal Pathway (MSK) has been reviewed and a new pathway is being implemented building upon the success of the Physio First model. Further work is required in 2018/19 to finalise the full integration with orthopaedics.

d. We will redesign the services we commission for urology to move appropriate services into the community, including erectile dysfunction.

e. Neurology – the key focus of pathway redesign in this area has been for headaches and migraines. Further work will now take place to redesign pathways for other neurological conditions e.g. Parkinsons's.

f. Ophthalmology - work has taken place to improve access to assessment and treatment services for all eye conditions, across a number of providers. Redesign work has taken place in some areas, however, further work is needed during 2018/19 to implement proposals such as:

    i. The Re-commissioning of cataract services to improve access

    ii. Re-commissioning the Wet Age-related Macular Degeneration service with a focus on reducing waiting times and improving access.

g. Renal – pathway review and redesign will focus on Acute Kidney Injury (AKI) to strengthen identification in Primary Care thus reducing hospital admissions and supporting secondary care with their 'alert' service.

h. Dermatology - in partnership, we will develop and implement an integrated dermatology service model which includes opportunities for enhanced management of skin conditions in Primary Care, a rolling programme of joint educational events on dermatological conditions and greater utilisation of tele-dermatology.

i. Gynaecology – we will review current pathways with a view to identifying opportunities for implementation of best practice.

Starting Well

57. We will look to secure care closer to home/in the community, where safe to do so, to improve choice and support independence for individuals and their families/carers.

58. We will continue to encourage our providers to actively promote and provide age appropriate information and to review their promotion of local health care services through mobile technology and social media to ensure that the use of such technology is optimised.

Maternity

59. We will implement the outcome of the maternity case mix acuity review, following utilisation of the local maternity dataset (to benchmark against peer and national case mix) to reduce variation, release efficiencies, and highlight good practice, whilst maintaining safe and high quality care.

60. We will continue to work in partnership across our local maternity system to implement the recommendations set out in Better Births: The National Maternity Review (February 2016) and support the Cheshire and Merseyside Maternity Pioneer and Early Adopter work, including implementing Personal Maternity Budgets following the regional pilot and continuing to promote and support choice through the ongoing implementation of the shared referral pathways and shared care pathways.

61. We will continue to collaborate with key local commissioners and providers to identify and agree shared maternity outcomes and to develop a contracting and finance framework for the commissioning for outcomes approach, to be informed by the NHS England and NHS Improvement reforms in this area, piloted in 2017/18 and implemented in 2018/19. The continued focus on Public Health outcomes, such as smoking and obesity, as part of the ongoing “fit for pregnancy” (maternity health optimisation) work, aligns to the NHS Five Year Forward View.

Children and Young People’s services

62. We will continue to collaborate with the Local Authority, Primary Care and local schools to increase activity levels for primary school Children (nursery to year 6) within the West Cheshire area to support the prevention of long term conditions, including obesity prevention via the continued rollout and sustainability of the Smile for a Mile programme.

63. We will implement a new Joint Commissioning Strategy for Children’s and Young People’s Speech and Language Therapy services, including a review of commissioning arrangements, an updated service specification with care pathways and key local quality requirements, following a jointly led review with the Local Authority.

64. We will implement the outcomes of the ongoing joint review of the existing Child Development Service with the local authority, in

collaboration with key health providers, which may include the introduction of an overarching service specification, or service level agreement amongst health providers, including key local quality requirements, and a review of the location of the current service.

65. We will promote the ongoing implementation of the co-designed self-care pathways to maximise the ability of Children/Young People and their parents/carers, where appropriate, to self-care, particularly those with a long-term condition, such as diabetes, asthma, epilepsy and mental ill health.

66. We will review the findings of the North West Paediatric Critical Care Network's benchmarking of Paediatric High Dependency Care services across District General Hospital's and Tertiary Centre's against the Royal College of Paediatrics and Child Health document 'High Dependency Care for Children – Time to Move' (October 2014) and agree and monitor the standards required by each provider Trust delivering care.

67. We will continue to jointly redesign paediatric services with the Acute Trust to reduce demand and take cost out of the system, whilst retaining quality services and continuing to integrate paediatric expertise within the community and Primary Care, including extending the scope of the redesign to all hospital services, accessed by Children and Young People, including the Emergency Department.

68. Building on the success of the Paediatric Consultant Telephone Advice Line for GPs, to secure full roll out in 2018/19 to fully utilise the available resource and maximise its benefits.

69. We will continue to review and monitor the Acute Trust's response to meeting the RCPCH Facing the Future: Standards for Acute General Paediatric Services and the Facing the Future: Together for Child Health Standards.

70. We will continue to explore the opportunity for consolidation of an Acute Care Alliance between the Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust to create a clinically integrated service between providers and a new model of care for women and Children's services.

71. We will begin to explore the opportunity to work more closely with the Local Authority to commission Children's services across health, education and social care.

72. We will look to maintain You're Welcome quality standard accreditation as a quality requirement of key health providers. Patient Experience Intelligence Report 2016/17 refers.

73. We will continue to work with the Local Authority and key health providers to meet our statutory duties in relation to SEND and effectively meet the needs of disabled Children and Young People and those who have special educational needs.

Medicines Management

74. Overall our focus on medicines management is to ensure effective use of benchmarking information and best practice intelligence to support prescribers to make high quality cost effective prescribing decisions. This includes working collaboratively across commissioners and providers to develop system-wide medicines management approaches and ensure all pathway redesigns include consideration of the medicines management aspects (including community pharmacy).

75. We will continue to focus on minimising waste through continuing our approach with GP practices on repeat prescribing, including awareness-raising with the local population of how they can help.

76. We will work closely with our providers to ensure adherence to West Cheshire CCG Area Prescribing Committee processes, for introduction of the new drugs, formulary review and development of guidance, pathway changes including shared care and will look to expand this to include medical devices.

77. We will work with Hospital@Home to ensure formulary and pathways are appropriate.

78. We will ensure that specials are only prescribed or recommended after due consideration of the risks, benefits and any licenced off-label product is contra-indicated or not tolerated. The provider must fully counsel the patient or carer regarding the unlicensed nature of specials.

79. We will ensure the antibiotic formulary is in place and reviewed annually, all clinical staff are to be aware of the antibiotic formulary and policy and educated regarding antibiotic resistance.

80. We will ensure our Providers have a timely clinical response to all drug applications, formulary and guideline development review.

81. We will seek to ensure there are no requests to Primary Care or other providers to prescribe non-formulary drugs, appliances or dressings and no patient to be treated outside the agreed pathways and policies.

82. We will ensure all treatments required prior to a planned procedure are prescribed or issued by the provider, including any formulary adjustments with all associated monitoring and interpretation of results to be undertaken by the provider.

83. We will ensure all unplanned admissions related to medication are to be identified and reported to the patient's GP and providers, carers or care home.

84. We will continue to ensure the contractual requirements in relation to immediately necessary treatment are adhered to.

85. On discharge from hospital all patients requiring ongoing treatment will receive a minimum of 14 days' medication, 5 days' dressings and sufficient stoma or continence appliances to last until the first review appointment or one month if the review appointment is later that one month post discharge. This intention must not delay discharge (i.e. weekends). Community pharmacies will be notified of any monitored dosage systems newly initiated by the provider within a timescale to ensure continuity of supply.

86. We will ensure the service specification for enteral feeds is agreed by all stakeholders and will look to review commissioning arrangements across a wider footprint. Use of homecare companies are to be risk assessed and all necessary governance and monitoring arrangements to be in place.

87. The self-care and gluten free policies will be reviewed in line with neighbouring Clinical Commissioning Groups and the national consultation.

88. We will continue to seek opportunities to increase the use/switch patients to relevant biosimilars, where applicable.

Mental Health and Learning Disability Services

89. We will look to build on the progress made within the Cheshire & Merseyside Sustainability and Transformation Plan mental health programme and the developing Integrated Care Partnership, in exploring what aspects of mental health and learning disabilities could be commissioned on a wider footprint (for example the successful regional work on eating disorder services) and where local commissioning and ownership is required. The Clinical Commissioning Group will work closely with the Local Authority to pilot more integrated health and social care commissioning for both mental health and learning disabilities

In addition, we will specifically look to;

Children and Young People's Mental Health

90. We will continue to work with Child and Adolescent Mental Health services and the other local Clinical Commissioning Groups in Cheshire to support and develop a focused Child and Young People Crisis Care Service, which sits alongside the Core 24 Crisis Liaison Service, enabling telephone crisis support and risk assessment during the weekend in order to reduce paediatric ward admissions for emotional and mental health crises and increase management of crises in the community.

91. We will work in collaboration with our Local Authority and partner Clinical Commissioning Groups to consider the development of a Single Point of Access for children, young people and families to access the

right mental health support service at the right time with minimal delays.

92. We will continue to drive the development of the workforce, through specific mental health training, to enable children and young people to have broader access to mental health support earlier including through schools.

93. We will continue to support local healthcare providers to develop new models of care, to ensure a reduction of children and young people inpatient admissions and an increase in appropriate home and community based mental health support.

94. We will continue to support the development of a local Eating Disorder Pathway to ensure children and young people with an Eating Disorder receive the right physical health and psychiatric care at the right time, in the right place by the right clinician and that generalist clinicians are supported with these patients with specialist needs.

95. We will ensure effective integration of mental health commissioning and provider expertise to meet our statutory duties in relation to SEND.

All age Mental Health and Learning Disabilities

96. We will commission a comprehensive all age crisis and liaison service that meets the requirements of 'Core 24', learning from early implementer sites.

97. We will review both the Children and Young Peoples and Adult Autism Spectrum Disorder/ Attention Deficit Hyperactivity Disorder pathways to ensure that services are as effective as possible. This may result in the procurement of a new pathway of care.

98. We will continue the review of home treatment services, ensuring that these services are as responsive as possible, meeting the needs of those in the community and avoiding admission/readmission into acute Mental Health services and attendance at acute services.

99. Review and evaluate the Acquired Brain Injury pathway to include effective triage of referrals and ensuring that there is a clear pathway for those no longer requiring inpatient services. This may result in the procurement of a new pathway of care.

100. We will continue to reviewing our case management arrangements in relation to complex patients, ensuring that individuals are appropriately placed and that the necessary clinical reviews are undertaken (and clients remain in inpatient provision for the shortest time possible).

101. We will continue to work on Mental Health care pathways with specialised commissioning teams to reduce demand across the system.

102. We will continue to work with the Local Authority on the delivery of the Dementia Strategy and action plan which focuses on access, diagnosis and ongoing support and we are reviewing the dementia pathway and service provision to support our Integrated Community Care Teams and clusters, as part of the development of integrated teams.

103. We will build on the work of the Dementia Friendly Communities to raise awareness of the importance of early diagnosis and create communities that support people with dementia to live independently for as long as possible implementing the commitments from the Prime Minister's Challenge on Dementia.

104. We will continue to improve access to psychological therapies ensuring that our health economy continues to deliver the key targets set out nationally and supporting the expectations of NHS Cheshire & Merseyside.

105. We will support the closure of Learning Disability hospital beds and use of out of area beds to support the development of community learning disability intensive support teams.

106. We will work closely with individuals with Learning Disabilities and Primary Care to ensure health checks are offered and taken up as a valuable opportunity to understand each individual's needs, promote healthy lifestyle choices and assess/identify risk factors.

Primary Care services

107. As West Cheshire moves towards an integrated care partnership; continuing to increase access, develop new ways of working and integrate clinical pathways between Primary Care, Acute and Community services will be key. Within 2018/19, the Clinical Commissioning Group intends to support Primary Care through this transition via a number of key schemes. In addition, the Clinical Commissioning Group intends to take on full delegated commissioning of GP Practices. Key commissioning intentions include:

108. Continuing the development of the Primary Care Commissioning for Quality and Innovation Scheme (CQUIN) to incentivise practices to transition towards a more integrated approach for care delivery, focused and monitored via the achievement of West Cheshire Way outcomes. Within 2017/18, this has already led to a complex system of multiple payment schemes being rationalised into one broader outcomes based scheme. This work will continue with a focus on; vulnerable patients including exploring cluster working and improved skill mix, outcomes

based long-term conditions management. This scheme will also support GP Practices to develop services that can be delivered between providers and over a “neighbourhood model”, focusing on population health outcomes and increasing efficiencies via economies of scale.

109. Increasing access to Primary Care and the range of services available within the community will be a continued focus. As West Cheshire was successful as a GP Access Fund site, significant work has already taken place to increase sessions available for extended hours and the range of services available for patients within the out of hours period, including for example, physiotherapy first, mental health services and social prescribing via Wellbeing Co-ordinators. This service will continue to play a key role within 2018/19 and publicity to the wider patient population will continue.

110. Via the GP Forward View Programme, significant work has already taken place to increase the training and development opportunities for Practice administrative and clinical staff, for example, by increasing understanding and utilisation of relevant and local signposting. Practices are also being encouraged to develop and work collaboratively, by participating within the Releasing Time for Care Programme. This work will continue within 2018/19, with the Clinical Commissioning Group supporting practices to look at greater skill mix and participate in schemes that will increase the sustainability of Primary Care e.g. via the International Recruitment Programme, by working collaboratively with the University to develop additional local opportunities for newly qualified clinical staff and developing alternative methods of access for patients e.g. E-Consult.

111. Through national funding streams, work will continue to support estates development within Primary Care, to meet the demands of an increasing population and to improve the quality and range of services our Practices are able to provide within their local community. This will be supported by the significant national investment in our ICT Infrastructure, modernising Practice systems to enhance data security and improve the ability to work more flexibly across Cluster localities.

112. Work will continue to take place with Practices to ensure unwarranted variation is reduced and NHS wastage is limited. Within 2017/18, the Clinical Commissioning Group has implemented a “Support and Escalation Process”, requiring Practices to investigate areas of performance that are significantly different to our local average, e.g. in relation to GP referrals or inpatient emergency admissions. This work will continue within 2018/19, with further work taking place including comparison to other health systems with comparable demographics.

113. Progress continues to be made with our two Clusters that work towards a population health neighbourhood care model; Broxton and Princeway. The Clinical Commissioning Group will continue to support this work,

identifying and resolving barriers to integration between primary care and the community care team as well as engaging with social care to enable greater autonomy for decision-making within the neighbourhood to avoid unnecessary admission to hospital and for more people to be managed effectively through end of life.

114. We will review the Pharmacy First Scheme as well as taking the opportunity to ensure use of our community pharmacies is maximized, to allow patients the alternative of attending at a pharmacy, to receive relevant medications and advice that would have otherwise involved a GP appointment.

115. A key element of delivery within the Integrated Care Partnership will be primary care. We will continue to work with GP practices as members and through the GP Federation, Primary Care Cheshire in the development of a model that is sustainable and works at scale in an integrated way with all other elements of the system.

Continuing Health Care funding/Complex Care Assessments

116. We will continue to work with neighbouring Clinical Commissioning Groups across Cheshire & Wirral to ensure the processes for Continuing Healthcare are adhered to, that patients are reviewed in a timely manner to minimise the risk of disparity of care with need and to implement national/regional identified best practice.

117. The clinical commissioning group will work with the Local Authority to review all patients who are non-Continuing Healthcare but have not previously received a full care assessment to ensure their needs are being met effectively. We will also continue to focus on complex patients place out of area to, where possible, consider locally commissioned alternatives in collaboration with partners, individuals and their families.

118. We will review the commissioning process for complex care and identify opportunities to increase the standardisation of approach including the agreement of packages and timely review.

Better Care Fund

119. The planning arrangements for the Better Care Fund are aligned to the national planning timescales and reflect the need to develop and agree the Better Care Fund for the next two years.

120. The clinical commissioning group will continue to work closely with Vale Royal Clinical Commissioning Group and Local Authority to ensure that the Better Care Fund proposals fully reflect our commitment to deliver the West Cheshire Way and an Integrated Care Partnership. This will require a realignment of priorities whilst ensuring we meet the

requirement to deliver a reduction in Delayed Transfers of Care and the priorities set out by the Accident & Emergency Delivery Board.

Commissioning For Quality and Innovation

121. National Commissioning for Quality and Innovation Scheme guidance for 2017-19 allocates 1.5% of the contract value against national schemes and the remaining 1% has been allocated as follows: 0.5% to be held in the risk reserve and the remainder 0.5% to be given for full provider engagement and commitment to the Sustainability and Transformation Plan process.

122. Table 5 below details the key commissioning for quality and innovation scheme areas for 2017-19:

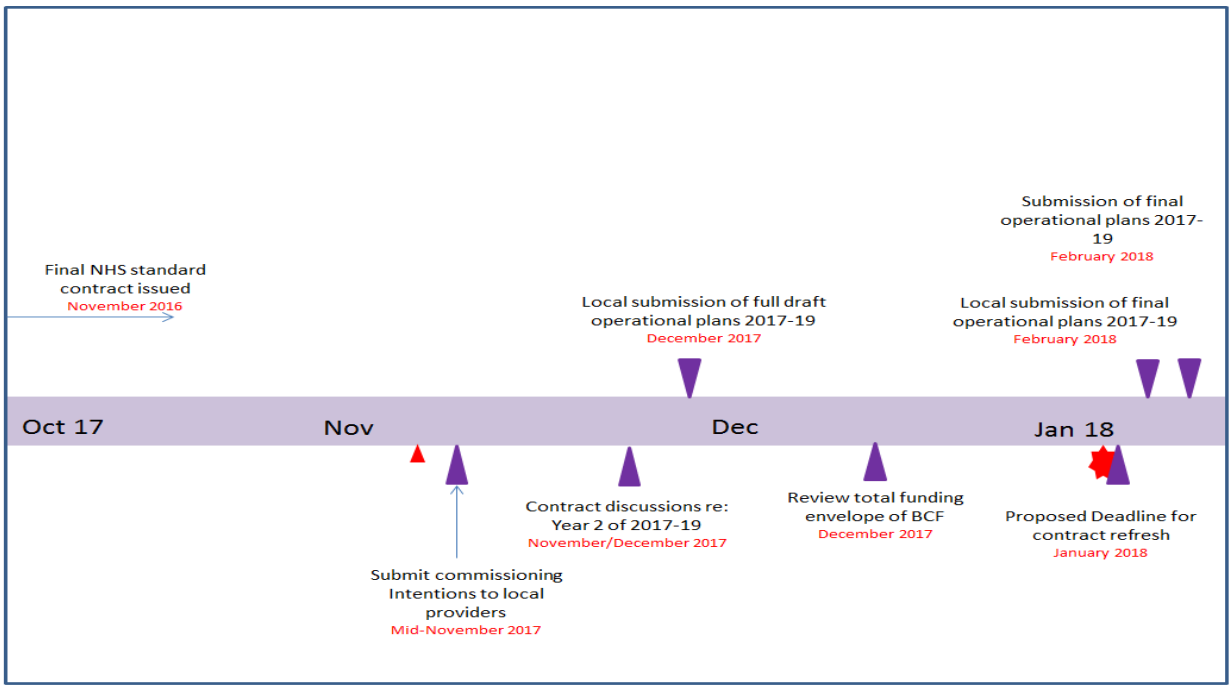
Table 5 - Key commissioning for quality and innovation scheme areas for 2017-19

Goal Detail (NB: 2 year duration)	Acute	Community	MH	Care Homes	Ambulance	111
NHS Staff Health and Wellbeing: Part a: Improvement of Health and Wellbeing for all staff Part b: Healthy Food for NHS Staff, visitors and patients Part c: Improving the uptake of flu vacinations for front line staff within Providers	P	P	P	P	P	P
Proactive and Safe Discharge Part a: Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories and undertake clinical audit Part b: Increasing proportion of patients discharged to their usual place of residence within 7 days of admission to 70%	P	P		P		
Reducing the impact of serious infections: Part a: Timely identification and treatment for sepsis in emergency departments and acute inpatient settings Part b: Empiric review of antibiotic prescriptions Part c: Reduction in antibiotic consumption per 1,000 admissions	P					
Wound Care: Increase the number of wounds which have failed to heal within 4 weeks that receive a full wound assessment		P				
Physical Health for people with Severe Mental Illness: Part a: Improving Physical healthcare to reduce premature mortality in peoplew ith SMI Part b: Collaborating with primary care clinicians			P			
Improving services for people with Mental Health needs who present to A&E Mental Health and Acute Hospital providers working together with partners to ensure that people presenting at A&E with primary or secondary mental health needs have these needs met more effectively through an improved, integrated service offer, with the result that A&E attendances are reduced	P		P			
Child and Young Person MH Transition: Incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS).			P			
Advice and Guidance: Set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.	P					
Personalised Care / support planning: 1. Establish provider systems to either; capture care and support planning as an activity or, as a minimum, to identify the cohorts of patients who would benefit most from the delivery of personlised care and support planning 2. Identify relevant patient populations, focusing on those with multi-morbidity, those with low levels of activation, support to self care or confidence to self care 3. Ensure that all relevant provider staff are suffifiently competent in holding care and support planning discussions with patients, through appropriate training 4. Conducting a baseline review of patient activation for the identified patient population		P				
E-Referrals (Year 1 Acute): All providers to publish ALL Of their services and make ALL of their First OutPatient Appointment slots available on eRS by 31 March 2018	P					
Preventing ill health by risky behaviours – alcohol and tobacco (Year 2 for Acute): Part a: Tobacco screening Part b: Tobacco brief advice Part c: Tobacco referral and Nicotine Replacement Therapy (NRT) Part d: Alcohol screening Part e: Alcohol brief advice Part f: Alcohol referral		P	P			

Delivery timeline

123. Figure 6 depicts the key milestone timeline for the update of the commissioning intentions for 2018-20 and its inclusion in the draft Operational Plan due in December 2017.

Diagram 6 - Commissioning timeline – key milestones



CAPACITY TO DELIVER THE INTENTIONS

124. The challenges as set out previously to the Finance, Performance and Commissioning Committee in relation to 2018/19 are significant. The focus in 2018/20 will be on the delivery of the system wide Financial Recovery Plan and associated efficiency initiatives which mirror the requirements of the NHS Cheshire and Merseyside Transformation Plan. The ability of the Clinical Commissioning Group to deliver its statutory responsibilities, particularly financial balance, whilst moving forward with integrated care will require careful management of capacity and the need to form aligned teams with local providers, as well as with the local authority and/or other local Clinical Commissioning Groups for some specific areas of responsibility.

RECOMMENDATIONS

125. The Finance, Performance and Commissioning Committee is asked to:

a. Support the refreshed Commissioning Intentions for 2018/19 and then agree their inclusion into the refreshed operational plan .

Gareth James
Chief Finance Officer

Laura Marsh
Director of Commissioning

November 2017