Executive Summary

The attached document is the latest version of the draft Commissioning Intentions 2013/14 that was submitted to the NHS Commissioning Board for authorisation. The Governing Body is asked to note both the document and the fact that the next draft will be available by 24th December 2012. The timetable for finalisation of both the Commissioning Intentions and our 2013/14 Operating Plan is 1th January 2013. Financial allocations we hope will be available nationally later in December.

The document reaffirms the broad priorities agreed at the Governing Body Seminar held on 28th November 2012 but will be updated to take into account the specific comments about strengthening secondary/primary care integration and wider 24 hour community services. The priorities flow from the JSNA refresh agreed by the shadow Governing Body and the Health and Wellbeing Board in September 2012 as well as the Community Based Care Strategy that we have produced as CCGs across South East London and our joint commissioning priorities with the London Borough of Bexley and Greenwich and Bromley CCGs.

Priorities cover both health services and health improvement (especially obesity) and are split into the two streams of:-

- Maintain and develop
- Step change and transform

The next version will reflect:-

- Clinical/GP and partner feedback from the last engagement event on 11th October
- the NHS National Mandate priorities
- NCB London priorities and process for primary care and specialised commissioning
- one integrated timetable drawing together local, South East London, London and national priorities into a unified approach
- joint and collaborative commissioning priorities with the London Borough of Bexley and our fellow CCGs across South East London
- integration of the TSA recommendations and the Bexley CCG commissioning intentions for Queen Mary’s Sidcup into the overall approach
- a drawing together of our main overall priorities for quality improvement, performance management and acting on patient and public feedback.

Preaderi (who have been supporting our work on the QMS Campus) have been contracted to provide support to the Interim Director of Commissioning, covering maternity leave, for this work.
It should also be noted that the next GP event and Primary Care Advisory Group planned for 17th January 2013 will be the next big engagement opportunity, both for the wider CCG membership and our partners across Bexley to guide our priorities.

Contract negotiation teams by provider are being assembled alongside shaping negotiating strategies – working closely with the Commissioning Support Unit for acute contracts. Aligning TSA, our own and acute financial and activity assumptions is proving complex and will be essential to minimising financial risk.

Appendix 1 shows the latest version of our Transformation Plan which is closely allied to the Community Based Care Strategy and targets both service redesign and more effective contract management opportunities that must deliver our QIPP 2013/14 total, currently estimated to be £10.5 million. It also sets out double running/bridging costs to enable new services to be established in advance of reducing our dependence on acute services and programme management one-off support to ensure that we can have as many schemes as possible scoped, modelled, costed and ready to start on 1st April 2013.

**Organisational implications**

<table>
<thead>
<tr>
<th>Financial</th>
<th>Supports delivery of 2013/14 QIPP and financial balance/surplus as required</th>
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<tbody>
<tr>
<td>Equality and Diversity</td>
<td>Commissioning Intentions are based on the Public Health focused JSNA view of rational priorities endorsed by the Health and Wellbeing Board</td>
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<tr>
<td>Risk (governance and/or clinical)</td>
<td>Capacity to deliver change in a turbulent, post-TSA environment, mitigated by double running costs of new services and programme support on a one-off basis. Aligning financial and activity assumptions with TSA assumptions and 2013/14 acute over performance – and ensuring that acute capacity reduction is delivered as the new services take effect in the community.</td>
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<tr>
<td>Patient impact</td>
<td>Closer to home focus at QMS Campus and development of enhanced community response</td>
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**NHS constitution**

Which objective does this paper support?

- Improve choice and access to integrated health services for Bexley patients ✓
- Reduce the level of health inequalities across Bexley ✓
- Improve care for patients with long term conditions & increase the range of services offered within the community ✓
- Improving the health & wellbeing for people in Bexley ✓
- Maximizing the opportunities of joint working (A Picture of Health, Joint Strategy Needs Assessment, Wellness agenda etc) ✓
- Using our resources in the most efficient & effective manner (organisational & financial) ✓

**Consideration by Other Committees/Groups**

Approved by: Executive Management Committee 06/12/12

**Author**

Mike Attwood  
Interim Director of Commissioning

**Executive Sponsor**

Mike Attwood  
Interim Director of Commissioning

**Date** 03/12/12
FOREWORD

Bexley Clinical Commissioning Group (CCG), in collaboration with the people and communities of Bexley aspires to commission high quality services, driven by real need, clear goals and within resources available, with the aim of producing visible improvements in outcomes and patient experience.

These Commissioning Intentions set out our practical plan to deliver improvements in both health and health services in Bexley next year, drawing from our longer term Commissioning Strategy Plan for 2013/14 and beyond. Our aim is to bring our QIPP (quality, innovation, productivity and partnership) plans more fully into our Commissioning Strategy Plan using one overall approach, because we will only succeed if we commission services that are “better for less”. Mainstreaming QIPP is essential to achieving this.

We are also building in the key messages from our refresh of the Joint Strategic Needs Assessment and the agreed priorities for the Joint Health and Wellbeing Strategy, currently in production. We have also conducted a brief but focused “Strategic Stock Take” to draw out the key priorities that emerge from our performance trends in 2012/13, our service quality monitoring systems, patient and public feedback and Board Assurance/risk profiling.

We will continue to ensure that local services are transformed through partnership working with patients, the public, our members, the London Borough of Bexley, our key NHS provider organisations and other key stakeholders. These Commissioning Intentions will be tested out with partners at a planned Whole System Listening Event on 18th October 2012.

2013/14 is a year of major transition for Bexley as we take on our new role in shadow form as a Clinical Commissioning Group from 1st October 2012 and play our full part in shaping the new ten year Community Based Care Strategy for South East London, led by the Trust Special Administrator for South London Healthcare Trust (SLHT), appointed by the Secretary of State for Heath. His second role is to stabilise SLHT as an organisation. His recommendations to the Secretary of State will be made towards the end of October 2012, with a final decision, following engagement, expected in January/early February 2013.

This means that despite such unprecedented change across our whole system, we must show leadership and create our own certainty for 2013/14. Partnership and collaborative commissioning are key to our success and this document also covers our joint priorities, both with the London Borough of Bexley and across Bexley, Bromley and Greenwich and wider South East London CCGs.

Our approach in 2013/14 is to make a step change to create a much more transformational QIPP that becomes our core commissioning strategy rather than being a semi-detached savings plan. At its heart is a step change towards a comprehensive community/closer to home model of service that will see a suite of services underpinned by a health hub delivered on the Queen Mary’s Hospital campus. We want to have in place a 16 hour Urgent Care Centre; elective surgery serving Bexley Bromley and Greenwich; 24 hour more intensive services for older people; a range of services for people with long term conditions starting with diabetes or needing anti-coagulation therapy; integrated services for children; mental health; community integrated stroke and neuro-disability services – plus specialist outreach radio- and chemotherapy. Clearly we need to be able to respond flexibly to the Trust Special Administrator’s recommendations, but we also need to be clear about our commissioning aspirations and make sure that we have credible business cases to make the case for integrated service model. We plan to use our 2% “top-slice” to establish these new models of service and cover double running costs, bridging change and reducing our acute spend and capacity in an orchestrated way across South East London together with our five partner CCGs.

We will hold to a clear vision and strategic approach to service delivery in Bexley, using this flexibly to implement the preferred eventual configuration of the NHS across South East London.
2 STRATEGIC STOCKTAKE FOR 2013/14

2.1 REFRESH OF THE JOINT STRATEGIC NEEDS ASSESSMENT

A refresh of our JSNA indicator set has been completed and the following joint priorities for 2013/14 have been agreed by the Health and Wellbeing Board at its September 2012 meeting:

- childhood and adult (new for 2013/14) obesity
- tobacco control
- nutrition in nursing homes
- dementia (new for 2013/14)
- diabetes (new for 2013/14)

The JSNA refresh also illustrates the continuing need to:

- reduce emergency/urgent admissions and length of stay across the board, including for older people, cancer, asthma and other long term conditions by further development of risk stratified prevention and 24 hour urgent care and re-ablement in the community
- prioritise the primary/community care components of planned elective pathways e.g for cardiology and musculoskeletal services integration.

The JSNA refresh was agreed by the CCG Shadow Governing Body and the Health and Wellbeing Board in September 2012. The Joint Health and Wellbeing Strategy will be produced by December 2012. In the meanwhile our key priorities for 2013.14 are as follows:

2.1.1 Adult Obesity

Adult obesity

26.4% of adults are obese (modelled estimate using HSE 2006-08) which is significantly worse than the England average 24.2%

The number of adults in Bexley who are physically active (9.2%) is significantly lower than the England average (11.2%)

According to the NHS Atlas of variation in health care (2010) Bexley had a very low rate of bariatric procedures compared to London and the rest of the country although this picture did improve in 2011.

The wards with the highest levels of obesity are North End, St. Michaels and East Wickham followed Belvedere, Crayford, Barnehurst and Danson Park
Table 1 People aged 65 and over who are obese or morbidly obese, by age and gender, projected to 2016 in Bexley. POPPI 2012

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<tbody>
<tr>
<td>People aged 65-69  with a BMI of 30 or more</td>
<td>3,477</td>
<td>3,603</td>
<td>3,666</td>
<td>3,666</td>
<td>3,666</td>
</tr>
<tr>
<td>People aged 70-74  with a BMI of 30 or more</td>
<td>2,406</td>
<td>2,463</td>
<td>2,466</td>
<td>2,523</td>
<td>2,694</td>
</tr>
<tr>
<td>People aged 75-79  with a BMI of 30 or more</td>
<td>1,940</td>
<td>1,940</td>
<td>1,961</td>
<td>1,961</td>
<td>1,940</td>
</tr>
<tr>
<td>People aged 80-84  with a BMI of 30 or more</td>
<td>1,224</td>
<td>1,241</td>
<td>1,241</td>
<td>1,241</td>
<td>1,265</td>
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2.1.2 Childhood Obesity

Data from the National Child Measurement Programme for the academic year 2010/2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Bexley</th>
<th>London</th>
<th>England</th>
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<tbody>
<tr>
<td>*Reception year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of children weighed and measured who are overweight</td>
<td>14.5 (389)</td>
<td>12.4</td>
<td>13.2</td>
</tr>
<tr>
<td>% of children weighed and measured who are obese</td>
<td>11.2 (299)</td>
<td>11.1</td>
<td>9.4</td>
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<tr>
<td>**Year 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of children weighed and measured who are overweight</td>
<td>16 (400)</td>
<td>15.1</td>
<td>14.4</td>
</tr>
<tr>
<td>% of children weighed and measured who are obese</td>
<td>21.3 (543)</td>
<td>21.9</td>
<td>19</td>
</tr>
</tbody>
</table>

*No of pupils 2806, No measured 2681, Coverage 95.5% Ranging from 84%-100%

** No of pupils 2806, No measured 2681, Coverage 95.5% Ranging from 84%-100%
Most adults with type 2 diabetes are diagnosed at around the age of 40. Alarmingly, Bexley has 7 children currently being treated for type 2 diabetes. To treat a child with type 2 diabetes costs on average approximately £2,217 per child per year for treatment alone. The cost of treating one child without complications from the age of 10 until the age of 40 would cost approximately £66,534.

The levels of overweight and obesity in children means that there will be a significant rise in the number of adults presenting with type 2 diabetes later in life.

The interventions listed below are delivered through Bexley BSU, they do not include interventions carried out by GPs or London Borough of Bexley.

- **Prevention**
  - Health Exercise Nutrition in the Really Young (HENRY) Training
  - Parents Education & Children’s Health (PEACH) programme
  - Health Improvement For Families workshops (HIFF)
  - *Lets Get Cooking
  - New Reception Children Induction Packs
  - Health Trainer support to parents of overweight and obese children

- **Management**
  - MoreLife (child weight management programme targeted at 7-11 year olds and their parents)

There is a non-recurring budget of £180,000 which funded the above programmes
*this programme was funded through public health nutrition budget.

From April 2013 there is currently no financial resource identified to contribute to a reduction in childhood obesity either through prevention or weight management programmes. There needs to be a review of how childhood obesity can be addressed by all partners across the borough. This will be led by the obesity taskforce group currently co-ordinated by LBB and will be dependent on the public health funding allocation and commitment from partners. An invest to save approach using n elements of our 2013/14 2% strategic change reserve will be adopted.
2.1.3 Tobacco Control

Tobacco Control

- Tobacco is the only legally available consumer product that kills people when it is used entirely as intended.*
- Smoking prevalence in England is estimated to be 21% of the adult population, there is no precise measure of smoking prevalence in Bexley (LHO Tobacco Control Profile 2012 measures prevalence at 18.1%)
- Bexley has a population of 232,000 according to the ONS 2011 UK Census. Based on a prevalence of 18.1% the number of smokers in Bexley is around 31,760.
- Tobacco industry targets youth to find 500 new smokers every day in the UK to replace smokers who stop or die.
- New smokers are mostly 11-15 year olds.
- Images of smoking as ‘cool’ are actively promoted on Facebook, Youtube, films, TV, social media and smoking paraphernalia given away at music festivals.
- Smoking is the primary cause of premature death and preventable illness.†
- Taxation of tobacco contributes £10 billion to HM Treasury annually; costs to society from smoking are £13.74 billion: treating smokers on the NHS (£2.7 billion); loss in productivity from smoking breaks (£2.9 billion) and increased absenteeism (£2.5 billion); cleaning up cigarette butts (£342 million); smoking-related house fires (£507 million), and the loss in economic output from the deaths of smokers (£4.1 billion) and passive smokers (£713 million)‡.
- 5% of all hospital admissions among those over 35§
- Passive smoking in the home is a major hazard to the health of millions of children in the UK who live with smokers**.

Smoking contributes to cardiovascular and respiratory diseases as well as many cancers. Bexley's successful stop smoking service consistently over achieves and is the only one in London to have all its 4 week quitters validated by carbon monoxide (CO) readers. Nationally and locally, smoking is the leading cause of preventable death and health inequalities and as a result there is a need to:

- raise awareness of the benefits of smoke free homes and cars, focusing on the most disadvantaged communities by working in partnership across public, voluntary and private sectors to protect children and adults from second hand smoke;
- increase the coverage of stop smoking services in clinical and community settings;
- support the Bexley Stop Smoking Service’s work in training and facilitating health professionals across the borough to deliver stop smoking support within the GP and pharmacy settings;

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* Oxford Medical Companion 1994
‡ Cough up: Balancing tobacco income and costs in society. Robert Nash & Henry, March 2010 Featherstone
§ Local Tobacco Control Profiles, London Health Observatory 2011
** Passive Smoking and Children: A Report by the Tobacco Advisory Group of the Royal College of Physicians March 2010
engage more pharmacies to offer smoking cessation support;
• develop more effective methods of identifying and preventing smoking in pregnancy;
• increase detection rates for COPD by screening all smokers aged 35+ with a 20 year history of smoking and offer smoking cessation support to this population;
• work in partnership to develop a tobacco control strategy;
• continue to target pregnant women, routine and manual workers and offer support to young people willing to quit smoking.

Current activities and services
• Bexley Stop Smoking Service offers evidence-based medication and behavioural support via a network of advisors in GP practices and pharmacies (Advisors trained by the core team provide stop smoking support as part of their generic role). The Service also has a small specialist team of Advisors (3 WTE). Comparatively low budget (£262 k)

• Trading Standards runs a rolling programme of test purchasing with retailers to ensure compliance and plans to involve young people in educating retailers in 2011/12.

• A pilot project is starting to train young people to influence peers; one through Bexleyheath Academy and one in Bexleyheath School. Budget: No additional money – provided from Stop Smoking Service and Children & Young People’s Team within Health Improvement.

Current annual spend is £262K

Gaps that need to be addressed
• Currently no information about the scale and impact of illegal trade in tobacco in Bexley. However Stop Smoking Service has contributed to a SEL Cluster-wide survey into the scale of illegal tobacco use in Bexley. Contribution has come from the Smoking Cessation Budget. Further investment in tobacco control will be required. Illegal tobacco is cheap and undermines the pricing policy which protects children from taking up smoking. The illegal tobacco trade is linked to other criminal activity and is a danger to children and communities.
• No strategic approach to prevent uptake of smoking among young people. No capacity within existing team to provide support.
• There is a gap in between the capacity of the stop smoking service and the number of smokers, only reaches around 5% of smokers
• Investment in Stop Smoking service is very low, particularly in comparison to other Stop Smoking Services in the SEL Cluster.
What we intend to do to address these gaps & build on existing good practice

- Smoking prevalence has fallen, but may not continue to do so because of recession and those still smoking are more heavily addicted and entrenched in their behaviour
- Users of addictive substances are likely to relapse at time of recession.
- Reduced budget for national campaigns e.g. national media and No Smoking Day
- Point of sales display legislation has come into force in large supermarkets
- Government considering plain packaging
- Risk that tobacco control loses its priority: belief that the existing legislation is sufficient. Regulation’s role to protect children not always recognised and questioned as ‘nanny statism’.
- Tobacco industry profits have increased with new markets opening up in emerging economies where regulation is minimal. The industry is still powerful and targets vulnerable groups e.g. young people in countries where regulation is tighter.

To address these gaps we should:

- Promote the de-normalisation of smoking
- Prioritise tackling illegal trade in tobacco products to protect children
- Focus on preventing uptake of smoking by young people
- Promote smokefree homes
- Ensure everyone in Bexley knows how to access help to stop smoking
- Ensure sign up and representation from all partners
2.2 COMMISSIONING STRATEGY PLAN (CSP) FOR 2013/14 AND BEYOND

The CSP is currently under development and will be ready by 31st March 2013. It will restate the joint priorities in the Health and Wellbeing Strategy set out in 2.1 above, but has as its major focus the NHS contribution to commissioning. This will include national and London-wide agreed priorities as well as our joint commissioning priorities with the London Borough of Bexley, with Bromley and Greenwich CCGs (our BBG programme) and across South East London as a whole.

The CSP will integrate the QIPP into it fully so that the approach is single and unified.

We plan to divide our strategic commissioning priorities into two categories:-

- **STEP CHANGE AND TRANSFORM** = more radical changes to the pattern of service delivery
- **MAINTAIN AND DEVELOP** = steady continuation within broadly similar resource and plans

This is important because we have to use what capacity we have as commissioners in a focused manner at a time of major transition.

The priorities to maintain and develop refer to services either where change is already well in hand and needs to be steadily embedded or where continual improvement rather than transformation or re-commissioning is the focus. We are assuming here that existing plans will continue and that there will be no significant change in 2013/14 that needs to be signalled in these commissioning intentions, apart from any updated national or London-wide priorities that emerge in the next three months.

The step change and transform priorities are the main areas for strategic focus and commissioning effort – and therefore the focus of these commissioning intentions.

We plan to sign off our plans for a strong “hub” for borough-wide services in Bexley during 2013/14. Our clear preference for this is a **campus on the Queen Mary’s Sidcup site** and this is an important cross-cutting development that underpins all our commissioning intentions.

Our **STEP CHANGE AND TRANSFORM** priorities for 2013/14 are:-

- **services for older people** – a step change in community based planned and urgent care
- **people with long term conditions** – with a particular focus on diabetes, cardiology, anticoagulation, musculoskeletal services and neurodisability
- **unscheduled care** – including mental health, substance misuse and alcohol services, plus sustainable achievement of the A+E 4 hour target
- **planned care** – redesign of referral management processes and levels, as well as the planned aspects of the long term conditions programme above
- **mental health** – dementia, embedding IAPT as a preventive,demand management programme and effective unscheduled care support to general acute settings as set out in the unscheduled care programme above
- **children’s services** - developing the safeguarding MASH and re-commissioning of specialist children’s services

The specific priorities for the coming year are as follows:-
2.2.1 Services for Older People
The key priorities for 2013/14 are those agreed by the Bexley Integrated Care Collaborative and comprise five areas of care:-

The overarching aim is to build a 24 hour integrated community service able to stratify risk, prevent admission and take a “pull” approach to discharge – with wraparound enablement services in place to reduce dependence on acute beds and local authority funded long-term care. There is a need to invest £2.8M as double running/pump-priming part-year effect from April comprising both health and social care developments, with an anticipated recurring saving effect on acute spend full year effect of £1.5M by the end of 2014/15.

2.2.2 People with Long Term Conditions

i) Diabetes

As obesity is a significant risk factor for diabetes it is not surprising that Bexley has as higher rate of diabetic patients diagnosed compared to the UK average. While this increase has been attributed to Bexley GPs being better at diagnosing diabetes than GPs in the rest of the country, this could also represent a higher than average incidence and prevalence - which would fit with the higher than average obesity rates. Whatever the cause, the result is many people with diabetes being needed to be treated. Initial indicators of quality of care for Bexley diabetic patients in 2009 were worse than the UK average but these have now improved. However Bexley still has higher than average admissions for acute renal failure which may be a reflection of morbidity due to diabetes and high diabetic related amputation rates. It has a very low insulin total net ingredient cost per patient on the GP diabetes register and high non-insulin anti-diabetic drugs total net ingredient. It is appropriate therefore to undertake a review of diabetes care. The JSNA therefore confirms the need to prioritise diabetic services.

The approach to diabetes will follow the Portsmouth model and aims to ensure consistent treatment in primary care, early identification of risk and prevention of admission, consistent standards of management in hospital as well as a rapid return to primary care. The new model follows the four tiers of care and ensures there is a smooth transition between each level of care under the auspices of a single provider. Wherever possible care will be centred within the community but when necessary patients can access secondary care for specialist care in renal and vascular disease and for obstetric and in-patient care.

The expectation is that the service will be tendered early in 2013 with implementation across Bexley early in the financial year 13/14. The main activity increase will be within the community at medical centres and GP practices for the majority of diabetes patients. This service will be lead, governanced and managed by Senior Consultant medical staff working alongside primary care colleagues. The Consultants will move back into the hospital to provide the specialist care when required. There is already a strong tier one and two level service within the GP practices and the new model will compliment and build on this base. With the additional strengthened community service it is anticipated that there will be a reduction of in-patients episodes, and a decrease in the number of patients requiring lower limb amputations.
The impact on the financial envelope of the new model is still under scrutiny but the current cost of OPD of £0.6M (4000 attendances per annum) should reduce when the new community clinics are in operation. It is much more difficult to estimate the cost of in-patient care for diabetes because most patients are admitted for problems associated with diabetes such as vascular necrosis. Once the full figures are available these will be circulated.

ii) Cardiology

The intention is to secure via tender a community based cardiology service provided by a single provider (via a restricted prime contractor procurement model) who will be responsible for the provision of local services. Within this approach, it is envisaged that the principle provider may sub-contract with other providers to provide the full range of services commissioned. This is a joint venture with Bromley. Significant cost efficiencies have been identified by remodelling this pathway with the potential for increased innovation. This procurement is due to commence in November 2012.

iii) Musculoskeletal Services

Within Bexley there is a significant higher than average number of inactive adults and obese children. Together with the overall increased level of adult obesity this has had an impact on MSK problems. This is confirmed in the rise in referrals to all MSK specialties including orthopaedics which has risen by just under 10% for the last two years, rheumatology which has risen by 46% over the last two years and Pain clinics. All these referral levels are high when benchmarked against regional and national averages. The impact on the local and health economy of MSK problems cannot be underestimated with 60% of long term sick leave attributed to MSK and 30% of attendances at GP surgeries for MSK problems.

The aim of the new service is to provide a fully integrated service (both out-patient and in-patient care) for patients suffering MSK problems within a fixed price envelope. The service will be expected to manage the patient’s condition from first presentation of pain, immobility, falling quality of life etc through to surgical intervention and/or long term self management solutions.

The specification of the new service includes 

**Triage**: A filter system which rapidly directs the patient to the healthcare professional most skilled to manage their MSK problem. National figures indicate that some 10% of referrals at this point require further refinement before progressing. This will replace the current triage service which has already undergone significant redesign to increase throughput and reduce costs (see MSK Triage below).

**Clinical Assessment and Treatment**: Patients requiring further assessment before a decision on care pathway can be directed to this intermediate services that will provide first line diagnosis, treatment and advice. The service will be led by a Senior Healthcare worker (such as Consultant in Rheumatology) who will ensure that the clinical team can quickly identify urgent cases and signpost them to specialities. The service will also provide a first step towards conservative management of other MSK problems including physiotherapy and an introduction to self management skills. Completion of care plans for all specialities and optimisation of patients before surgery/interventions will be part of the CATS responsibility.
Physiotherapy Service: A comprehensive physiotherapy service provided at multiple locations within each borough. The service will provide on-going treatment as outlined by the CATS service patient plan.

Speciality Services:

Orthopaedic Surgery: Timely access to surgical consultation and intervention through proper preparation and work-up of the patient to a point that DNAs and unnecessary referrals are reduced to a minimum. At the same time the service must ensure those patients ready and/or in need of the service gain access as quickly as possible. The service will provide excellent operative outcomes with short length of stays and the ability to refer back into the CATS system for post-operative physiotherapy support.

Rheumatology: Timely access to rheumatology expertise when CATS service assessment indicates this is necessary should reduce DNAs and unnecessary/wasted referrals.

Pain: Timely access to Pain expertise when CATS service assessment indicates this is necessary should reduce DNAs and unnecessary/wasted referrals.

The service will be tendered early in 2013 with the go-live anticipated during the first quarter or 13/14. There are several local providers of physiotherapy services as well as the main SLHT provision of Physiotherapy and specialist services. These stakeholders have all been involved in the redesign of MSK and will be qualified to bid for the new service.

The current cost of OPD and physiotherapy services is £6.61M with an additional estimated £30M on elective MSK surgery. From April onwards there will be an additional cost pressure of £1.129M as physiotherapy services are disaggregated from the block contract with SLHT. The PbR changes in April will also bring additional cost of imaging currently included within OPD consultations. The implications of this are as yet unknown but with the average price of an MRI at £200 it is likely to have a significant impact on budgets for 13/14.

iv) Neurodisability Services

The currently commissioned model at the Elmstead Unit relies on a relatively high level of beds for rehabilitation, with a strong focus on outpatient review. There is currently no community rehabilitation service for this group of people although a Bexley community stroke pilot is underway. There is also no day modality of service to allow for more intensive management of exacerbations or to deliver rehabilitation.

Our aim for Bexley is to procure an integrated “end-to-end” model of service based on an integrated stroke and neurodisability community rehabilitation team. Our current modelling suggests that we will require no more than 4 beds for Bexley. The new service will be rehabilitation oriented and actively focused on pain, symptom and exacerbation management, rather than respite.

The community team will manage the spectrum of interventions from home-based rehabilitation through to outpatient or fuller day assessment, treatment and rehabilitation with clear thresholds to access a bed. Greenwich and Bromley do not wish to commission any replacement beds, but may need occasional access to a bed if their local community rehabilitation teams and beds require inpatient support for particular cases.
This development requires us to go to full procurement on October 1st 2012. Six months’ has been given to SLHT on 30th September 2012 of our intent to decommission the Elmstead Unit for all three CCGs.

The newly commissioned integrated community neurology service with dedicated specialist in-patient neurorehabilitation provision with outpatient facility and ESD will be operational by April 1st 2013. This remodelled clinical pathway will create up to a 40% increase in community referrals from the acute setting. The introduction of a specialist community service has enabled Bexley to reduce the number of specialist in-patient rehabilitation beds by 50% and has created £52k QIPP saving. Since the opening of the Hyper Acute Stroke Unit (HASU) at the PRUH, considerable cost savings have occurred where patients have been directly discharged from the HASU due to reduced length of stay in an acute hospital setting for patients experiencing an acute stroke. As this continues to be successful the revised in-patient facility will be patients with a complex neurological disability only.

v) Anticoagulation

Warfarin is being used in the management of increasing numbers of patients and conditions including post-myocardial infarction, atrial fibrillation, DVTs and other disorders. While it is a very effective drug in these conditions, it can also have serious side effects, e.g. severe haemorrhage. These side effects correlate closely with the International Normalised Ratio (INR) level. The INR level measures the delay in the clotting of the blood caused by the warfarin. While the “normal” INR is 1, the target range of INR values depends on the disease and the clinical conditions. Warfarin monitoring aims to stabilise the INR within set limits to help prevent serious side-effects while maximising effective treatment.

The current service is provided by Secondary and Primary care depending on the patient acuity. The new model allows more patients to be seen closer to home and includes a comprehensive community anticoagulation service which will serve patients, aged 16 and over, registered to a GP practice within the London Borough of Bexley who require:

Anticoagulation Therapy service: Initiation of Warfarin Therapy
Anticoagulation Therapy service: On-going monitoring of INR for the purposes of ensuring warfarin dose remains therapeutic
Diagnosis of suspected Deep Venous Thromboembolism

The service has been divided into Tier 1 and Tier 2 services for procurement purposes. It is expected that bidders may tender for the Tier 1 service only, the Tier 2 service only or both tiers across one, two or all three boroughs. The Provider shall support an integrated approach between service providers whilst ensuring that patient records are transferred appropriately to support a seamless patient transfer and service provision.

Tier One: Initiation and on-going management of oral warfarin treatment (and where clinically appropriate low molecular weight heparin cover), taking appropriate blood samples, testing and providing dosing advice to patients, development and updating of written treatment plans. The service will include domiciliary visits to housebound patients for appropriate testing and management.
**Tier Two:** Assessment and management of suspected deep venous thrombo-embolism (DVT), initial management and referral of patients with proven DVT to Tier 2 services, assessment, initial treatment and hand-over of patients in whom DVT has been excluded.

Tenders have already been received for this service and contracts are expected to be awarded shortly. The main impact on current providers is that there will an increased number of providers giving patients more choice in where they attend for treatment. Tier two also allows more choice for patient suffering non-acute DVT and will provide access to speedier diagnosis and treatment.

The total impact of the Long term Conditions Programme is as follows:-

<table>
<thead>
<tr>
<th>YEAR</th>
<th>CURRENCY</th>
<th>DIABETES</th>
<th>MSK Full service</th>
<th>ANTICOAGULATION</th>
<th>MSK triage only (see comments under MSK)</th>
<th>NEURODISABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>Part Year Effect</td>
<td>Urgent Spells Urgent EBDs A+E attendances</td>
<td>Reduction in AE attendances has not yet been calculated. In year cost reduction already applied.</td>
<td>Estimated 5% reduction in AE attendances. Circa £0.4M</td>
<td>No activity change</td>
<td>No activity change</td>
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<td></td>
<td></td>
<td>TOTAL SAVING £'000</td>
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</tr>
<tr>
<td>2014/15</td>
<td>Full Year Effect</td>
<td>Urgent Spells Urgent EBDs A+E attendances</td>
<td>£350K reduction in costs already achieved. New model savings have yet to be defined.</td>
<td>Estimated 5% reduction in AE attendances. Circa: £0.5M</td>
<td>No activity change</td>
<td>No activity change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOTAL SAVING £'000</td>
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</table>

Reduction of 2035 Acute bed days in 13/14 Budget -£198k

406 Days remain in acute at cost of £139k

Community service 1247 Bed days plus Community attendances

Total Saving £43k

406 Days Reduction in acute cost of £139k

Community service additional 250 Bed days plus Community attendances

Total Saving £9k
<table>
<thead>
<tr>
<th>YEAR</th>
<th>CURRENCY</th>
<th>DIABETES</th>
<th>MSK Full service</th>
<th>ANTICOAGULATION</th>
<th>MSK triage only (see comments under MSK)</th>
<th>NEURODISABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14 Part Year Effect</td>
<td>Double running/pump-priming costs</td>
<td>TBA</td>
<td>Not available</td>
<td>None</td>
<td>£1.66M</td>
<td>N/A</td>
</tr>
<tr>
<td>2014/15 Full Year Effect</td>
<td>Ongoing new service costs</td>
<td>TBA</td>
<td>Circa £30M</td>
<td>New Service costs: £567K</td>
<td>£4.091M</td>
<td>£1,221,268</td>
</tr>
<tr>
<td>2013/14 Part Year Effect</td>
<td>Net saving or cost pressure when old and new services netted off</td>
<td>TBA</td>
<td>Estimated £3.5M</td>
<td>Net Savings: £255K</td>
<td>£0.859M</td>
<td>£43,000</td>
</tr>
<tr>
<td>2014/15 Full Year Effect</td>
<td>Net recurring saving or cost pressure when old and new services netted off</td>
<td>TBA</td>
<td>Estimated £4.5M</td>
<td>Net recurring savings: £255</td>
<td>£0.859M</td>
<td>£9000</td>
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</tbody>
</table>

2.2.3 Unscheduled Care

**QMS – URGENT CARE CENTRE**

We will implement the new 111 service from February 2013 and will decommission the Grabadoc telephone/triage service in parallel.

As part of the QMS Campus Business Case we will re-procure the current Urgent Care Centre service which is provided by two different providers in- and out of hours. The day service will therefore come out of the Oxleas block contract and the entire 24 hour service will be subject to re-procurement on a tariff-based approach using the London tariff. **Dependent on the TSA recommendations, this is likely to mean a 16 hour service.**

This requires six months’ notice to be given to Oxleas for the day service, Southern Healthcare for the night service and SLHT for the radiography supporting service. Notice will be given to Grabadoc of a contract variation for the removal of the telephone/triage service. In parallel we plan to review multiple access point services in North Bexley during 2013/4 in readiness for re-procurement by ¾ 2014.
Mental Health Urgent Care

Unscheduled Care

Currently in Bexley we have a range of services that support those requiring unscheduled care:

Oxleas Foundation Trust – Mental Health Crisis Team
- 24/7 response to adults with acute mental health problems who present in A&E and/or in the community. Their role is to review and assess patients as they present in crisis and provide the necessary specialist interventions ensuring reduced pressure on general acute services. If patients are not admitted to the acute mental health wards then they may be worked with on a short term basis at home and or sign posted to other alternative services. This includes those presenting with risks associated with alcohol, drug and self harm.

Together – Chapel Hill – Crisis and Respite Beds
- This service is available for patients who are in need of non-clinical crisis and respite services. Those appropriate for this service are supported 24/7 in a social setting. Referrals generally come from the crisis team and general mental health services.

Oxleas Foundation Trust – Specialist Dementia Unit at Queen Mary’s
- Bexley, Bromley and Greenwich have recently agreed to the re-configuration of older people’s inpatient dementia services, which has created a specialist dementia unit at Queen Mary’s with an emphasis on admission prevention, short admission and high quality packages of care on discharge from this unit. Commissioning this service together has provided flexibility with usage of resources and we now commission bed days instead of a set number of beds. This has helped to manage capacity and demand without the need for additional resource and pressure in the system.

Oxleas Foundation Trust – Psychiatric Liaison Service in A & E
- Oxleas have a psychiatric liaison service in place at Queen Elizabeth hospital which ensures patients presenting with sign of dementia are identified very quickly and managed in line with local referral protocol. This model ensures that there are no inappropriate admissions with regards to dementia, reduced length of stay by getting diagnosis right first time and ensuring wherever possible that the intervention is at home rather than an in-patient setting. The support at home will come via the local memory service and community mental health team.

Oxleas Foundation Trust – Memory Service
- Bexley have made significant investment into local memory services for early assessment and diagnosis of Dementia. This service helps to reduce hospital admissions and supports people to live well with dementia at home.
Alzheimers Society – Dementia Support and Advice Service

The Alzheimer’s Society provides social support and advice in the borough for patients and carers living with dementia. This is a preventative service, providing respite day services and on-going support and advice which contribute to the prevention of unscheduled care, whilst helping people to live well with Dementia.

IAPT Funding Requirement for 2013-14

The cost of 3 substantive posts at Step3 HI (Band 6) level will be required in order to fulfil our obligation under the IAPT training programme. The total cost will be £ 110,319.

Integration of Services Talking Therapy Services

Currently GPs refer into either of three services: IAPT, Counselling or Oxleas.

The IAPT and Counselling services are being tendered as an integrated service with a single point of entry to ensure referrals are treated by the most appropriate service and in line with patient choice. As part of this, GPs will be required to refer all cases of anxiety and depression to this service. All referrals will be triaged and any deemed to be severe will be directed to the Oxleas service.

Since Payment by Results clustering exercise Oxleas have been reporting referrals at Levels 1, 2 and 3 which are low to moderate severity depression and anxiety. Under current block contract arrangements patients may be treated but should ideally be directed towards the IAPT service. When Payment by Results is implemented Clusters 1-2-3 will not be commissioned from Oxleas, but patients may be inappropriately referred and the CCG will be charged for each separate assessment.

The number of patients clustered as 1-2-3 amounted to 470. There are no double running costs as the MIND IAPT service operates Step, 1, 2 and 3 IAPT services independently of Oxleas. When patients require stepping up to Step 4 they are referred to Oxleas. These patients will have severe and complex issues which fall outside the MIND IAPT service.

National QIPP Target

The IAPT service is part of the Talking Therapies initiative and is preventative, aiming to treat mild and moderate symptoms before they become severe and complex. The national target for IAPT is 15% of prevalence (24,735) of mental health disorders which equates to 3710 patients per annum being seen in the service by 2013/2014.

Waiting lists are high for Step 3 – this is experienced throughout IAPT services. The three Step3 trainees will help to reduce waiting lists when their training is complete and they work full-time in the service.
Demand management is difficult as self-referral is stipulated in DH guidance and services are unable to stipulate GP only referrals. The only management of demand we have is to stay within the current commissioning format of issuing a contract to a preferred provider. If Any Qualified Provider was adopted Bexley would have to contract with all suitably qualified Providers and each would drive up demand in order to receive payments.

Part-year savings could only be identified by reports from Oxleas of reduced referrals in Clusters 1-2-3. Oxleas are currently undertaking an exercise to check all Clustering around 1-2-3 as early clustering may include errors. It is difficult to verify data as Commissioners do not currently have access to patient records.

**Future – Service Capacity**

Savings may be possible in relation to cases of Severe Anxiety and Depression as the impact of IAPT cases seen at an early state, mild to moderate, start to take effect and people are seen before their symptoms reach “severe”. Cluster 4 will be monitored closely to see if this trend is emerging. The capacity of the service will be approximately 2375-2500 patients per annum (including Counselling referrals) – this represents 67% of the prevalence target.

**Mental Health Recovery Day Services**

We have recently reviewed the main day service providers in the borough to ensure we are meeting commissioning services that fully meet the recovery agenda. The findings of the review have identified some areas for improvement which will require some aspect of re-design and or re-commissioning. This work will improve recovery day service outcomes and ensure that all service users in Bexley have the best possible opportunity to recover from their mental health problems in line with national best practice. The action plan and further details will be available as this work progresses. Initial programme group meetings are taking place in October 2012.

**2.2.4 Planned Care**

This is an area of high risk given the 2012/13 QIPP risk already in the system for planned care. This comprises 580K for non-local acute services and 674K for outpatient services at SLHT that are likely to be carried forward, at least in part to 2013/14 – a total of £1.26M. Our 2013/14 draft QIPP anticipates a further £1.44M in addition to the Trust Special Administrator Community Based Care (CBC) Programme anticipating a further QIPP “stretch” for planned care of £3.77M by 2017/18 (£5.1M gross in their elective and outpatient categories, less the £1.44M already planned for 2013/14). Assuming that the TSA “stretch” element doesn’t start until 2014/15 this leaves a making a potential total of £2.7M for the QIPP planned care challenge in 2013/14 £1.44M plus £1.26M)

Projected acute over performance on planned care in 2012/13 also needs to be factored in, currently predicted to be a full year effect of £5M.

As a first step to stabilising the position, six months’ notice has already been served on the Patient Management Centre run by Bexley Health Limited, with re-procurement planned in the first quarter of 2013/14. Interim acute commissioning and demand management project management support is now finally in place with the aim to have the planned care element of the acute QIPP both for the remainder of 2012/12 and 2013/14 shaped and quantified into one plan by the end
of November 2012. We are also working with Practice Managers to ensure that they are able to produce demand management and referral trend report dates from the Mede system locally, rather than relying on the CCG to do this centrally.

We expect the impact of our Long Term Conditions Programme on planned care activity and spend to be as follows:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>CURRENCY</th>
<th>DIABETES</th>
<th>MSK full service</th>
<th>CARDIOLOGY</th>
<th>ANTICOAGULATION</th>
<th>MSK triage only (see comments)</th>
<th>NEURODISABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Specialty 314</td>
</tr>
<tr>
<td>Part Year</td>
<td>OPD New</td>
<td>New* 16,000</td>
<td>Reduction in OPD</td>
<td>Tier 1 Community</td>
<td>Reduction in OPD of up to</td>
<td>Reduction of 2035</td>
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<tr>
<td>Effect</td>
<td>OPD Follow-up</td>
<td>Fu* 35,000 under</td>
<td>anticipated. Results of</td>
<td>Tariff:</td>
<td>18% and transfer to</td>
<td>Acute bed days in</td>
<td></td>
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<tr>
<td></td>
<td>Day Case</td>
<td>community tariff.</td>
<td>national pilot expected</td>
<td>Monitoring</td>
<td>ICATS service</td>
<td>13/14 Budget - £198k</td>
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<tr>
<td></td>
<td>Elective Spells</td>
<td>Elective spells</td>
<td></td>
<td>appointment:</td>
<td></td>
<td>406 Days remain in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective EBDs</td>
<td>EBD = NA</td>
<td>Elective spell and EBD = TBA</td>
<td>27,985 @17.73 = £496,174.</td>
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<td>acute at cost of</td>
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<tr>
<td></td>
<td>Urgent Spells</td>
<td>Urgent spells and EBD = TBA</td>
<td></td>
<td>Initiation: 452 @£25 = £11,300</td>
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<td>£139k</td>
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<tr>
<td></td>
<td>Urgent EBDs</td>
<td>See previous table for savings</td>
<td></td>
<td>LMWH 80 @£50 = £4000</td>
<td>Tier 2:</td>
<td>Community service</td>
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<tr>
<td></td>
<td>A+E attendances</td>
<td></td>
<td></td>
<td>Tier 2:</td>
<td>DVT consultation</td>
<td>1247 Bed days plus</td>
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<td></td>
<td>TOTAL SAVING £’000</td>
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<td></td>
<td></td>
<td>1500@£25 = £37,500</td>
<td>Community attendances</td>
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<td></td>
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<td></td>
<td>US scan</td>
<td>720 X £50 = £36,000. For savings see previous table.</td>
<td>Total Saving £43k</td>
</tr>
<tr>
<td>YEAR</td>
<td>CURRENCY</td>
<td>DIABETES</td>
<td>MSK full service</td>
<td>CARDIOLOGY</td>
<td>ANTICOAGULATION</td>
<td>MSK triage only (see comments)</td>
<td>NEURODISABILITY</td>
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<tr>
<td><strong>2014/15 Full Year Effect</strong></td>
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<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>As above (recurrent)</td>
<td>Specialty 314</td>
<td>406 Days Reduction in acute cost of £139k</td>
</tr>
<tr>
<td></td>
<td>OPD New</td>
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<td></td>
<td>Community service additional 250 Bed days plus Community attendances</td>
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<td></td>
<td>OPD Follow-up</td>
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<td>Total Saving £9k</td>
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<tr>
<td></td>
<td>Day Case</td>
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<td>Elective Spells</td>
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<td>Elective EBDs</td>
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<td>Urgent Spells</td>
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<td>Urgent EBDs</td>
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<td>A+E attendances</td>
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<td>TOTAL SAVING £'000</td>
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<td><strong>2013/14 Part Year Effect</strong></td>
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<td>Double running/pump-priming costs</td>
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<tr>
<td><strong>2014/15 Full Year Effect</strong></td>
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<td>As previous table</td>
<td>As previous table</td>
<td>As previous table</td>
<td>As previous table</td>
<td>£1,221,268</td>
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<tr>
<td>YEAR</td>
<td>CURRENCY</td>
<td>DIABETES</td>
<td>MSK full service</td>
<td>CARDIOLOGY</td>
<td>ANTICOAGULATION</td>
<td>MSK triage only (see comments)</td>
<td>NEURODISABILITY</td>
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<tr>
<td>2013/14 Part Year Effect</td>
<td>Net saving or cost pressure when old and new services netted off</td>
<td>As previous table</td>
<td>As previous table</td>
<td>As previous table</td>
<td>As previous table</td>
<td>£43,000</td>
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<tr>
<td>2014/15 Full Year Effect</td>
<td>Net recurring saving or cost pressure when old and new services netted off</td>
<td>As previous table</td>
<td>As previous table</td>
<td>As previous table</td>
<td>As previous table</td>
<td>£9000</td>
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### 2.2.5 Dementia

**Development of GP Dementia QoF Pathway**

In addition to established Dementia services in the Borough (see below) we are in the process of developing a dementia pathway which will form part of the GP’s Quality and Outcomes Framework. This work will be piloted in the Clocktower area of Bexley and if successful will be reviewed for full roll out across the Borough. The focus of this work will be routine memory assessment to be included in physical health checks and annual medication reviews for all those over 65 years. We also aim to ensure that GP’s start to record diagnosis and we will be working towards a shared care protocol for yearly reviews of those that have been diagnosed with Dementia but are still living well. This will also be supported by pro-active approach to offering assessments for those that do not fall within the physical health or medication review checks.

**Development of local Dementia Strategy Outcomes Framework**

We have an established multiagency dementia strategy group in the Borough. We are developing a local outcomes framework which will identify areas of excellence and or areas for improvement which will be monitored using a RAG rated system. The action plan for the outcomes framework will be addressed by the local dementia strategy group and is subject to scrutiny under the health and well being board ensuring good local awareness and accountability for dementia services in the Borough.
Oxleas Foundation Trust – Psychiatric Liaison Service in A & E

Oxleas have a psychiatric liaison service in place at Queen Elizabeth hospital which ensures patients presenting with sign of dementia are identified very quickly and managed in line with local referral protocol. This model ensures that there are no inappropriate admissions with regards to dementia, reduced length of stay by getting diagnosis right first time and ensuring wherever possible that the intervention is at home rather than an in-patient setting. The support at home will come via the local memory service and community mental health team.

Oxleas Foundation Trust – Memory Service

Bexley have made significant investment into local memory services for early assessment and diagnosis of Dementia. This service helps to reduce hospital admissions and supports people to live well with dementia at home.

Alzheimer’s Society – Dementia Support and Advice Service

The Alzheimer’s Society provides social support and advice in the borough for patients and carers living with dementia. This is a preventative service, providing respite day services and on-going support and advice which contribute to the prevention of unscheduled care, whilst helping people to live well with Dementia.

2.2.6 Services for Children and Young People

Most of the developments planned for children’s services are in the “maintain and develop” category and are cost neutral. They will be tracked through the Bexley Children and Young People’s Plan and the Children’s Partnership Board. The “step change and transform” priorities are:

- To secure the future of specialist children’s community health services (currently with SLHT) by re-procuring to seek an appropriate community provider to deliver integrated care for children with additional and complex needs. This approach to include paediatric occupational and physiotherapy, currently separately specified. Also to be addressed within this exercise will be securing the future of tertiary paediatric audiology for Bexley, Bromley and Greenwich, and taking account of draft legislation on the Reform of Provision for Children and Young People with Special Educational Needs, which includes the opportunity for parents to ask for a personal budget for their child with complex needs. Notice will be given to SLHT of this intent with the re-commissioned service in place by July 2013.

- Although not fully within the service area, there is an urgent requirement to work with the London Borough of Bexley to commission health services similar to those currently provided in special schools, to support the development of local post-18 educational provision. It may be appropriate to commission an 18-25 service to include nursing and therapy services for young people in transition and those who are educated locally where they may previously have gone out of borough under the, now abolished, YPLA (Young Persons Learning Agency) arrangements. This would be in line with the new duty, under the aforementioned draft legislation on the Reform of provision for Children and Young People with Special Educational Needs,
to provide an Education, Health & Care Plan for children and young people with complex needs aged 0-25. Other alternatives to be considered will be spot purchasing (if numbers of young people are very small) or personal budgets.

- to support delivery of the Safeguarding Improvement Plan following the July 2012 OFSTED/CQC inspection – in particular making the case for investment into the Multiagency Safeguarding Hub (MASH) to enable better intelligence and smoother information sharing.

- We have invested considerably in CAMHS at the tier 3/4 end in last two years with the aim of reducing admissions particularly the long term ones for emerging personality disorders. However CAMHS has continued to be impacted by CRE’s imposed internally by Oxleas as in response to our on-going requirements for efficiencies. The outcome of this has been a raising of the thresholds at tier 2, which has been further exacerbated by the cessation of Extended Schools funding. As a result there is a rise in the severity and complexity of presentations to CAMHS and significant pressures on waiting times and caseloads. It is a false economy to disinvest in lower tier CAMHS as later presentations are more costly and more likely to transition into adult services. An initial discussion between child and adult mental healthy commissioners has resulted in the suggestion of a potential three year agreement to protect CAMHS from CRE’s (acknowledging the increased impact on adult services – but seeking a QIPP in regard to reduced transitions.

- Developing work with young people in the Youth Justice System is seeing increasing numbers diverted from the statutory route and reducing reoffending. Speech and language therapy input commissioned through the Point of Arrest Diversion scheme grant is identifying high levels of unmet communication needs in young people presenting through this route. A business case to commission a dedicated service – possibly linking to input to Trouble Families, may be indicated.

- We will need to have regard to how we can contribute to schemes which assist with the Troubled Families programme.

- In addition we will work with Greenwich and Bromley CCGs to agree a consistent model of care across BBG, including pathways and tariffs for acute and ambulatory paediatrics in time for 1st April 2013.

2.3 KEY PERFORMANCE ISSUES FROM 20012/13 THAT DRIVE 2013/14 PRIORITIES

This section sets out the main performance issues to be addressed in the 2013/14 contracting round. The commissioning action is set out along four options:

1) Performance Manage lead provider
2) Whole system performance Management
3) Cause not fully understood :service review in 2013/14
4) Strategic redesign → re-commission and procure
<table>
<thead>
<tr>
<th>TARGET</th>
<th>IMPROVEMENT MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients waiting Over 4 Hours - Type 1 &amp; 3 (SLHT)</td>
<td>Mainly green as reported by cluster – more fragile in practice-sustainability issue</td>
</tr>
<tr>
<td>98% of completed referrals for home equipment within seven days</td>
<td>3% improvement required in an average month</td>
</tr>
<tr>
<td>90% of all adult in-patients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (SLHT)</td>
<td>Fragile achievement – current range of 83.5-91.2% up until July 2012</td>
</tr>
<tr>
<td>90% Category C ambulance Calls answered within 60 minutes</td>
<td>July performance 86.6%</td>
</tr>
<tr>
<td>Ambulance calls abandonment (0.19%) and re-contact rates (CTA) – (4.1%)</td>
<td>Rates are 0.18% and 4.3% in July respectively</td>
</tr>
<tr>
<td>Ambulance calls closed with telephone advice (CTA) – 6.5%</td>
<td>5.33% in July</td>
</tr>
<tr>
<td>Cancer 62 day wait – 86% treated in 62 days from GP referral, consultant referral and referral from screening programme</td>
<td>Fragile – performance dipped to 80.36% in July. July 11 Breaches - 10 at SLHT, 1 UGI, 6 Lung, 1 Urology, 1 Skin, 1 Lung, 1 at KINGS Breast</td>
</tr>
<tr>
<td>93% of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected</td>
<td>Fragile-amber 92.11% in July</td>
</tr>
<tr>
<td>85% patients receive 1st definitive treatment within 62 days of urgent GP referral for suspected cancer</td>
<td>Fragile – 76.19% in July</td>
</tr>
<tr>
<td>98% of women with an expected date of delivery for their cervical screening test result within 14 days of the test being taken</td>
<td>Fragile – 96.58% in July</td>
</tr>
<tr>
<td>Access to dentistry – current 24 month measure</td>
<td>Need to improve by 3.83% - NCB handover issue</td>
</tr>
<tr>
<td>Volumes of first and follow-up outpatient referrals</td>
<td>Amber – awaiting September figures</td>
</tr>
<tr>
<td>RTT - admitted Trauma and Orthopaedics – SLHT – 90%</td>
<td>Amber – 85.71% in July</td>
</tr>
<tr>
<td>RTT – admitted – Bariatric surgery – SLHT</td>
<td></td>
</tr>
<tr>
<td>Total numbers waiting at the end of the month on an incomplete RTT pathway</td>
<td>Target 9800 – actual 11313 in July</td>
</tr>
<tr>
<td><strong>TARGET</strong></td>
<td><strong>IMPROVEMENT MEASURE</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Number of patients, at the date of measurement, waiting 6 weeks or more for an MRI or CAT scan</td>
<td>Red in July – 4 breaches year to date</td>
</tr>
<tr>
<td>Number of patients, at the date of measurement, waiting 6 weeks or more for other diagnostic tests and procedures</td>
<td>Red in July - 28 breaches year to date</td>
</tr>
<tr>
<td>Total number of diagnostic endoscopy tests</td>
<td>Amber in July – 35 short of target of 548 in July</td>
</tr>
<tr>
<td>Secondary User Experience - Proportion of Complaints resolved locally within an agreed timescale. Plan based on 11/12 KPI</td>
<td>Red – Oxleas achieving 50% against 95% target in July</td>
</tr>
<tr>
<td>Extension of bowel screening program to men and women aged 70 up to 75 birthday</td>
<td>Red – 3.66% only against a target of 50.4% in July</td>
</tr>
<tr>
<td>Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours</td>
<td>Red only 30.5% against 60% target in July</td>
</tr>
<tr>
<td>The number of new cases of psychosis served by early intervention teams year to date</td>
<td>5 against target of 7 in July 2012</td>
</tr>
<tr>
<td>The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (SQU16_01 / SQU16_02)</td>
<td>0.74% against target of 1.16%</td>
</tr>
<tr>
<td>90% women have seen a midwife by 12 days and 6 days of pregnancy</td>
<td>Amber 97.19% in July 2012</td>
</tr>
<tr>
<td>All childhood immunisation programmes</td>
<td>Much improved—now mainly amber – less than 1% to go but needs to sustain</td>
</tr>
<tr>
<td>Percentage of new birth Health Visitor visits carried out to Bexley Babies within 14 days</td>
<td>69% against 85% target in July</td>
</tr>
<tr>
<td>Oxleas – Falls in the Step Up/Step Down service</td>
<td>Red – 15 falls in serious harm category as defined by the NPSA in Q1 2012/13</td>
</tr>
</tbody>
</table>
2.4 KEY QUALITY ISSUES FROM 2012/13 THAT DRIVE 2013/14 PRIORITIES

EARLY DRAFT SECTION

<table>
<thead>
<tr>
<th>QUALITY ISSUE</th>
<th>IMPROVEMENT MEASURE</th>
<th>COMMISSIONING ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCC IT issue between daytime and night service - two providers</td>
<td>Information agreement as temporary solution but needs to be one provider</td>
<td>Re-procure UCC with one provider</td>
</tr>
<tr>
<td>Community transport</td>
<td>SI and their management patient feedback</td>
<td>Tender community service</td>
</tr>
<tr>
<td>SI reporting Oxleas</td>
<td>Through challenge at Quality meetings</td>
<td>Penalties in contract if requirement not met</td>
</tr>
<tr>
<td>DVH performance</td>
<td>NED to NED/ attendance at Quality</td>
<td></td>
</tr>
</tbody>
</table>

2.5 KEY PATIENT AND PUBLIC FEEDBACK THEMES REQUIRING COMMISSIONING ACTION IN 2013/14

INITIAL SUMMARY AT END OCTOBER 2012

Acute Provider – SLHT

- Savoy Transport & SLHT contract monitoring
  - Delays (over two hours, quality of service – patient falls resulting in injury, monitoring of compliance with contract specification and failure to adequately respond to complaints

- Orthopaedics – operations cancelled and long delays in obtaining an appointment following referral
  - Some problems were linked with closure of ITU at QMS site

- Gynaecology
  - Several reports of cancelled operations (one on the day after patient admitted), also delays in reading test results leading to delays in patients being referred for further necessary treatment
• Maternity
  o Two very serious cases brought to our attention but investigated by SLHT, both relate to mothers who unfortunately had still births following what they claim to be poor care and treatment from staff (referred to CQAG for monitoring) [for info LINKs is carrying out a survey on Maternity, as has been a major issue to their members]

• Oral Surgery
  o Extremely long delays following referral, delays in consultant triaging referral, admin and clerical staff shortages leading to delays in correspondence and telephone access (calls consistently not answered and voice box full)

• Ophthalmology & Dermatology
  o Appointment and treatment delays

Commissioning Concerns

• IFRs
  o Long delays in communication and decisions; especially IVF

• Mental Health Commissioning
  • Funding for CBT /treatment’s etc (commissioners shave to agree for it to follow pathway)

Oxleas

• District Nursing
  o Poor standards care, poor record keeping

• Continence services
  o Change in supply of pants to pads and quantity

GP

• Patient removal from lists
  o Med’s changed /brand/quantity
• Diff making appointment/telephone access
• Difficulty in registration
Failure to visit
Refusal to refer
Non compliance with NHS Complaints regulations
Use of 084 numbers

During November work will be undertaken to inform quality specifications, CQUINS and new contract levers-work in progress at end October 2012.

3.0 FINANCIAL OUTLOOK

The CCG has an agreed 3-year plan (2012/13-2014/15) that ensures achievement of statutory duties and the 1% required surplus over the 3-year planning period 2012/13-2014/15. However, achievement of this assumes that the plan will be delivered in each of the financial years. In 2012/13, significant over-performance has once again been seen within the acute sector, which is being covered in-year from non-recurrent means. Furthermore, the existence of a cap & collar agreement with South London Healthcare NHS Trust has resulted in a benefit to Bexley in this financial year. These non-recurrent means are in addition to the £4.8m financial support received which must be repaid by 2014/15.

In the summer the Government appointed a Trust Special Administrator (TSA) to South London Healthcare NHS Trust to look at the viability of services across the Trust and South East London. Part of this work was to look at the financial gap across the commissioners and providers. A new set of planning assumptions have been discussed and agreed with Chief Financial Officers across the CCGs and these have resulted in a larger gap than the original 3-year plans submitted and agreed by each organisation.

The main changes from original assumptions are as follows:

- Increase in recurrent resource limit
- Increase in non-demographic growth
- Increase in tariff / inflation uplift

Using the McKinsey (TSA financial support) planning assumptions (table 1 below) and the 2012/13 plan, the financial gap (QIPP requirement) has been assessed. This is considered to be £6.5m for 2013/14 and £1.4m for 2014/15. The assessed gap for Bexley is significantly less than for other CCGs, mainly due to assumptions around moving income to target. However, in addition to the new gap, Bexley has seen significant over-performance within the acute sector again during this financial year. This is being covered in-year from non-recurrent means of £7.6m. Furthermore, the existence of a cap & collar agreement with South London Healthcare NHS Trust, has resulted in a benefit to Bexley of £2.4m in this financial year. These non-recurrent means are in addition to the £4.8m financial support received which must be repaid by 2014/15, but which is already included within the McKinsey / TSA plans. The 2012/13 position has therefore been assessed, as at month 6, to establish the recurrent and non-recurrent elements of both expenditure and resources. This has resulted in an assessed gap / QIPP requirement of £10.4m and £2.2m in 2013/14 and 2014/15 respectively (table 2 below).
Table 1 – Planning assumptions

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Acute</td>
<td>Client</td>
<td>Primary</td>
<td>Corporate</td>
<td>Other</td>
<td>Total</td>
<td>Acute</td>
<td>Client</td>
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<tr>
<td>Recurrent Revenue uplift</td>
<td>2.73%</td>
<td>2.73%</td>
<td>2.73%</td>
<td>2.73%</td>
<td>2.73%</td>
<td>2.73%</td>
<td>2.73%</td>
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<tr>
<td>demographic Growth</td>
<td>0.43%</td>
<td>0.43%</td>
<td>0.43%</td>
<td>0.43%</td>
<td>0.43%</td>
<td>0.43%</td>
<td>0.43%</td>
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</tr>
<tr>
<td>Non-demographic growth</td>
<td>2.00%</td>
<td>2.00%</td>
<td>1.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>1.00%</td>
<td>2.00%</td>
</tr>
<tr>
<td>Total population &amp; incidence growth</td>
<td>2.43%</td>
<td>2.43%</td>
<td>1.43%</td>
<td>2.09%</td>
<td>2.43%</td>
<td>2.43%</td>
<td>1.43%</td>
<td>2.08%</td>
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<tr>
<td>Prescribing growth</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>Tariff/ Inflation Uplift</td>
<td>2.70%</td>
<td>2.70%</td>
<td>1.00%</td>
<td>2.23%</td>
<td>2.70%</td>
<td>2.70%</td>
<td>1.00%</td>
<td>2.22%</td>
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<tr>
<td>Tariff efficiency assumption/ Price Efficiency applied</td>
<td>(4.00%)</td>
<td>(4.00%)</td>
<td>(3.04%)</td>
<td>(4.00%)</td>
<td>(4.00%)</td>
<td>(3.04%)</td>
<td>(4.00%)</td>
<td>(3.01%)</td>
</tr>
<tr>
<td>Net Tariff/ Inflation Uplift</td>
<td>(1.30%)</td>
<td>(1.30%)</td>
<td>0.00%</td>
<td>(0.81%)</td>
<td>(1.30%)</td>
<td>(1.30%)</td>
<td>0.00%</td>
<td>(0.79%)</td>
</tr>
</tbody>
</table>

Table 2 – Bottom up calculation of QIPP requirement

<table>
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<tr>
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<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
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<tr>
<td>Latest TSA plans - assumes no / little change to current 3-year plans</td>
<td>7584</td>
<td>3100</td>
<td>1100</td>
<td>1100</td>
<td>1100</td>
<td>1100</td>
<td>7500</td>
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<tr>
<td>Additional not in TSA plans to meet 1% surplus and repay financial support</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Difference between TSA plans and simple planning template using TSA planning assumptions</td>
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<td></td>
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<tr>
<td>Acute overperformance</td>
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<tr>
<td>Difference between SLHT activity &amp;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction to over-performance for N/R GSTT &amp; Kings - assumes as 2% support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health over-performance</td>
<td>0</td>
<td>500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Continuing care over-performance</td>
<td>0</td>
<td>300</td>
<td>0</td>
<td>0</td>
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<td>300</td>
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<tr>
<td>SLA reserve</td>
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<td>0</td>
<td>0</td>
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<td>-2405</td>
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<td>Prescribing reserve</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-400</td>
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<tr>
<td>Budget reserve</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-991</td>
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<tr>
<td>Total QIPP required</td>
<td>0</td>
<td>11207</td>
<td>1369</td>
<td>-2765</td>
<td>-1538</td>
<td>-459</td>
<td>7814</td>
</tr>
<tr>
<td>Delay of repayment of financial support</td>
<td>0</td>
<td>-882</td>
<td>882</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total QIPP required assuming financial support deferred</td>
<td>0</td>
<td>10325</td>
<td>2251</td>
<td>-2765</td>
<td>-1538</td>
<td>-459</td>
<td>7814</td>
</tr>
</tbody>
</table>
These assumptions will be refined as planning progresses to take account of:

- Any updates to the 2012/13 position;
- Any changes in Payments by Results for 2013/14;
- Any changes in the market forces factor following any change in hospital configuration or patient flow as a result of TSA recommendations;
- Any changes to the allocation methodology for CCGs;
- Reductions to allocations for services transferring to other commissioners, including public health, primary care & specialist commissioning;

It is vital that the CCG moves from transactional QIPP to transformational to secure the level of QIPP required to ensure financial sustainability. The CCG will submit business cases, to the National Commissioning Board, against the 2% non-recurrent resource for 2013/14 and 2014/15 as a source of investment for pump priming QIPP and ensure its delivery.

Other risks include

- continuing care - 300K minimum
- mental health cost per case – to be scoped by 30/11/12
- primary care QOFF and other practice claims for payment being handed over to NCB – scoped by 30/11/12
- out of borough children’s Special Residential Schools (Alison R)

There is an emerging cost pressure for 2013 and beyond caused by the transfer back to the LA of responsibility for post-18 education for young people with learning difficulties previously funded by the YPLA. LBB and Bexley Care Trust are apparently one of only three areas nationally which have not contributed to the social and health elements of the funding of such places (in Independent Specialist Provision) in the past. The cost of the placements of the current 3 cohorts of learners is £1.76 m. LBB will seek to recover the health elements of these costs (amount to be determined but potentially up to a third) from Bexley CCG. LBB is looking at options to reduce the pressure by providing such education locally and would be aiming in the first year to provide local placements for up to four learners. BCCG will need to consider options for meeting the health needs of learners either through commissioning a dedicated service, spot purchasing or (in line with the SEND Green Paper) offering personal budgets. The CCG will need to fund the health needs of learners who cannot initially be educated locally.
4.0 NATIONAL EXPECTATIONS FOR THE 2013/14 PLANNING CYCLE


5.0 LONDON-WIDE COMMISSIONING PRIORITIES

Awaiting input from London NCB LAT. CSU supporting early contact re; specialised commissioning during November 2012.

6.0 Managing the 2012/13 Contracting Round

Detailed negotiation plans and contract teams are currently being put together and where possible these will be joint across BBG (as they already are for SLHT) and with the London Borough of Bexley. This will particularly affect the Oxleas Contract, South London and Maudsley Contract and the Kitemark, all of which include public health elements of responsibility for contracts transferring to the Council. A weekly Contracting Round 2013/14 team meeting has been established. The man risk is scoping activity assumptions for acute providers.

As the BSU will be undertaking contract negotiations, in legal terms, on behalf of the shadow CCG, we are following a standard SEL wide process of contract derogation/novation to ensure that the responsibilities and inheritance of the CCG and other “receiving” bodies is clear. The Commissioning Support Unit has produced a draft timetable to be further refined at a joint CSU/CCGs event on 17th October. This will need to pick up the London Local Area Team (LAT) of the National Commissioning Board’s (NCB), timetable for specialised commissioning, other London-wide programmes and primary care contracting for GPs, dentists, optometrists and community pharmacists.

6.1 General Principles – To be further developed

Risk based approach to contract negotiation –

- List of contracts to be renegotiated
- Anticipated Changes in contract “vehicle” e.g. to AQP, open tender etc.
- Co-ordinating and Associate Commissioner Arrangements

- Productivity and Efficiency Assumptions
- CQUINS and incentivising quality
• **Payment by Results Further Development**

PbR will continue in shadow form in 2013/14 for mental health, but it is essential that Bexley CCG is fully engaged in the national modelling of this and the impact on our contracts in time for go live in 2014/15. PbR overall presents a number of new opportunities and risks in 2013/14:-

- Unbundling of diagnostic imaging from outpatient tariff which may push the pace of our service redesign programme
- Implementation of the 2012/13 shadow maternity pathway as mandatory under 2013/13 PbR
- Top up funding for specialised services – a **risk transferring to the NCB**
- A range of new amended best practice tariffs becoming mandatory in 2013/14
- New mandatory chemotherapy and radiotherapy tariffs
- Possible changes to neurology and neurosurgery outpatient tariffs on a mandatory basis
- Mandatory tariffs with local prices for specialist rehabilitation and HIV outpatients
- Development of “year of care” programmes during 2013/14 for possible implementation in 2014/15

• **Collaborative Commissioning**

**LONDON BOROUGH OF BEXLEY**

During 2013/14 we aim to consolidate and strengthen our approach to joint commissioning in Bexley. We have already refreshed the JSNA and published and agreed joint priorities for the Joint Health and Wellbeing Strategy that will be completed by 1st November. Alongside this we plan to publish **joint strategic commissioning intentions** by the **end of October 2012**. An approach has already been agreed to update our **Section 75 agreements** and to appoint a **Head of Joint Commissioning** during the remainder of 2012/13, subject to the national HR rules and London ring fencing arrangements being run as part of CCG transition. This section **does not repeat** NHS lead priority areas of work, but instead focuses on **joint strategic action** where both organisations can make more difference together than apart.
The key areas of joint action are:

Carers’ Strategy

CCG budget is 257K +100K unassigned-plan to be in place by March 2013

Older People

Mental Health

The existing section 75 agreement has worked very well for mental health services in the Borough over r the past 10 years. We would support the continuation of the section 75 agreement. We are in the process of re-establishing a joint commissioning board with the local authority which would be a good place to present and discuss innovation and improvement with regard to section 75 arrangements both now and in the future.

Learning Disability Services

Peter Buck to complete as he is overseeing the LD SAF and what we need to do – by end November 2012

Physical Disability

Bexley is procuring early supported discharge (ESD) as part of the new integrated specialist neurology service redesign pathway. This will enable appropriate stroke patients to leave hospital ‘early’ through the provision of intense rehabilitation in the community at a similar level to stroke unit care. For the duration they would otherwise have been receiving inpatient rehabilitation (usually up to two weeks), stroke and other neurological condition patients receive at least five sessions per week of occupational therapy, physiotherapy and speech and language therapy as required. Following the initial intensive rehabilitation period in the community, the therapy regime reverts to a level of normal community rehabilitation as required (i.e., at least three sessions per week of appropriate therapy). The introduction of ESD to this clinical pathway will potentially create a 40% increase in community referrals from the acute setting.

A critical component of the Bexley community rehabilitation stroke pilot pathway was the recruitment to an Occupational Therapist role that was employed to train home care staff within the Reablement Team to support patients to gain functional independence and life skills, assist at midway reviews, and ensure patients have on-going links with their local community upon discharge from the reablement services.

Reablement involves, typically, six weeks of intensive home-based support to help people recover independence following crisis or hospital discharge, and is seen as a crucial way of minimising costs to health and social care.
Where health and social care services work together to facilitate a smooth return home for patients, it can enable quicker recovery outcomes, reduce pressure on the patient and their families and prevent unnecessary readmissions to hospital or care homes. Subsequently Bexley Local Authority is seeking to jointly procure this post with Bexley Care Trust as part of the overall new integrated specialist neurology service redesign pathway. Continued funding of this post would be cost neutral to Bexley as it will continued to be funded by the Local Authority.

Children and Young People

London Borough of Bexley has an interest in the commissioning of specialist children’s community health services, especially in relation to Speech and Language Therapy, and will be involved in the procurement process to ensure that services continue to be integrated and seamless. Commissioning will also need to have regard to requirements of SEND Green Paper which moves to Education, Health and Care Plans, single assessments and personal budgets/direct payments for children with complex needs.

3rd Sector Grants Programme

As part of the Joint Commissioning work with the London Borough of Bexley, it has been agreed that the contracts with the third sector for both the CCG and the Local Authority will be extended until October 2013 when both organisations will be in a position to jointly re-procure services which meet the needs of the local population. The CCG value of grants is £407523 during the period of the extension, staff in both organisations will be undertaking a deep dive review of the services currently provided by the third sector organisations and assessing how these meet the needs of the local population in terms of outcomes. Once this information is available, then in conjunction with the Carers’ Strategy and the Health and Well-Being Strategy, commissioning decisions can be jointly made as to how the envelope available from both parties can be best utilised to provide tangible outcomes for the residents of Bexley who require these services.

Section 75

Currently the CCG has a number of Section 75 agreements in place with the London Borough of Bexley and a paper is to be presented to both the CCG Board and the Health and Well-Being Board to suggest going forward there should be one overarching Section 75 agreement upon which other arrangements can added as further elements of joint commissioning are agreed and further developed. This agreement would need to be approved by lawyers and also CCGs would need in statute to be able to hold Section 75 agreements but in anticipation of these issues work is being undertaken 3rd

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National Stroke Strategy, 2007
SOUTH EAST LONDON (SEL) CLINICAL COMMISSIONING GROUPS

A framework for joint working, risk sharing and collaborative commissioning was agreed by all six emerging CCGs during September 2012. This is critical as we draw together the ten year strategy for the development of Community Based Care working with the Trust Special Administrator. A SEL Programme Director had been appointed and the Bexley, Bromley and Greenwich (BBG) Programme Office will work closely with the SEL-wide Programme Office. There is a BBG clinical Strategy Group and a Shared Standards Board in place. The focus is on “Shared Standards: Local Delivery” to ensure that we work coherently on strategic change, shape mutually reinforcing care pathways and manage the pace of change and stranded costs with providers that are subject to major reconfiguration such as SLHT.

We run a common Contract Management Board across BBG for the SLHT contract and will explore the same for mental health (BBG) and community services (jointly with Greenwich) for 2013/14, the first step being simultaneous working on our separate contracts to ensure alignment. Our joint commissioning intentions cover the following:-

- shared standards for anticoagulation services (AQP), MSK, cardiology, diabetes and neuro rehabilitation services in readiness for procurement
- joint re-procurement of our Patient Management (Referral) Centre with Greenwich, given that we share the same provider
- consultant advice sessions to reduce/replace outpatients, jointly initially with Bromley

We are also setting up a SEL wide medicines management programme.

7.0 IMPLICATIONS BY PROVIDER – a section to be written for each provider by the end of November

SLHT, DV, GSTT, Kings, Lewisham

Oxleas Community

Oxleas Mental Health

The Department of Health has mandated the introduction of Payment by Results (PbR) for mental services nationally from 1st April 2013. We will be monitoring activity and performance (outcomes) in line with the new mental health clustering framework where patients are allocated to a cluster based on their mental health needs. For 2013-14 the contract will be funded in line with the existing block contract arrangements as the (PbR) cluster pricing is reliant on the quality of the clustering information and nationally it is recognised that data quality needs to improve in order to develop and agree actual cluster prices to ensure no unexpected cost pressures for the commissioner or the provider.

With this in mind we will be working jointly with Oxleas over the next 18 months via sequence of (PbR) sub groups which will provide a whole system approach to the transition from block payment to payment by results. This new model of payment will provide detailed reporting about outcomes and help the CCG to make informed decisions about their commissioning intentions and will ensure we continue to commission high quality services with a good recovery that are good value for money.
Our existing contract with Oxleas Foundation Trust for acute & community mental health services is due to come to an end on 31st March 2013. Although this contract is specific to Bexley; Bromley and Greenwich are bi-lateral organisations to this contract, which means we all commission our acute & community mental health services from Oxleas. We collaborate on service delivery and re-design where there is perceived benefit and or opportunity to improve service delivery and access for all our patients. Bexley, Bromley and Greenwich commissioners have reviewed, discussed and agreed that there are no other local providers that could meet the current service delivery models for the 3 respective boroughs as of 1st April 2014. Therefore it is our intention to continue to commission these services with Oxleas from 1st April 2013 for a further 3 years under the terms of a new NHS national contract.

Bexley and Greenwich Community Hospice
Ellenor Lions

MIND

Mind in Bexley are currently commissioned to provide a range of mental health services in the Borough. These are IAPT, Mental Health support services and a Personalisation Centre for Mental Well Being (Pilot). We have been committed to ensuring the third sector have a strong presence in the borough offering a non-clinical approach to the recovery of those who experience mental health problems. This includes those that may have received treatment within the statutory sector and or those who require some support to prevent the need for them secondary mental health service interventions.

IAPT

The IAPT service (Improving Access to Psychological Support) has been successfully implemented in the borough in line with national guidance and strategy. This service has proven very successful in the prevention and intervention for those experiencing mild to moderate mental health issues. The contract for IAPT services in Bexley is due to cease on 31st March 2013, therefore this service is currently being re-procured in line with national procurement legislation. The new contract for the provision of IAPT services in Bexley is due to be awarded by March 2013, to ensure the new service provider can commence as of 1st April 2013. The procurement process for this contract has been very successful and we have fully engaged in with the public and we are also pleased to confirm that we have had an ex service user who has overseen the tender process.

Mind Personalisation Centre for Mental Well Being

The government announced in 2012 that health care services needed to start progressing in line with local authorities to offer services that met the personalisation agenda by offering individual person centred services, based on assessed need, where the service user decides how they want their services to be provided. In order to understand how this would translate to mental health services we decided to create a pilot scheme to help us develop a model that met the personalisation agenda. This is currently block funded, however following a 6 month review we will review the success of the pilot and decide how we will take this forward and implement fully in the Borough. This work is due to commence in January 2012 and will be a joint working group with the local authority to ensure the personalisation agenda is fully met and offered in a sustainable model for the future.
Mind Mental Health Centre – IMHA & General Support

Mind in Bexley are commissioned to provide a range of support and guidance to those experiencing mental health problems in the Borough. This ranges from welfare rights and employment support to peer support groups and access to physical health trainers, providing a whole system approach to mental health recovery and well-being. This contract is performing well and we continue to monitor their performance on a quarterly basis.

Together – Martin/Emma

Together are commissioned to provide two specific service models in Bexley. They provide residential rehabilitation supported housing and crisis and respite beds and they are also commissioned to provide an alternative to care service which supports people to live well in their own homes and prevent the need for full time residential care placements. Both these contracts are funded via the section 75 arrangements.

Chapel Hill Residential Rehabilitation & Support Houses

Chapel Hill provides rehabilitation, respite and crisis beds to mental health service users in the borough and at other supported houses. This service helps and supports people to regain their independence and independent living skills, as they continue to recover from their mental health problems. This service is commissioned under the section 75 arrangement.

Alternative to Care

The service is a Supported Sheltered Housing Scheme for people with mental health problems, who may have experienced difficulties in maintaining their own tenancy or living independently in the community. Clients are allocated a set number of hours over a period of time, based on assessed need. This service is commissioned under the section 75 arrangements.

The service is intended to be an alternative to residential care, so applicants may be moving from residential care or other support setting such as hospital, or may be diverted from residential care because their needs can be met appropriately within their own tenancy.

The scheme is working in partnership with Oxleas NHS Trust, Bexley Council and the various housing associations providing sheltered accommodation within the borough.

Bexley Community and Mental Health services Limited

Bexley Community and Mental Health services limited have been providing primary care counselling in the borough. As part of the IAPT service re-tender it was discussed and agreed via consultation that the primary care counselling service would be integrated into IAPT as this will contribute to a more effective whole system approach. This contract is therefore currently being re-tendered as part of the IAPT tender.
First Step Trust

First Step Trust provides a social inclusion and employment service to those recovering from mental health problems in the borough. Offering work experience in a range of occupations. This service is commissioned under section 75 arrangements and is currently being reviewed along with all existing mental health recovery day services in the borough to ensure we are commissioning services which enable recovery in line with best practice.

Re-Instate

Re-Instate provides a social inclusion and employment service to those recovering from mental health problems in the borough. Offering a workshop environment to gain work experience and skills and also arranging work placements at external organisations. This service is commissioned under section 75 arrangements and is currently being reviewed along with all existing mental health recovery day services in the borough to ensure we are commissioning services which enable recovery in line with best practice.

Alzheimers Society – Martin/Emma

The Alzheimer’s Society provide support and guidance to patients diagnosed with dementia and their carers. The support ranges from group sessions to 1:1 welfare advice and future planning as their dementia progresses. They work closely with Oxleas Memory Service to ensure an integrated pathway of care is provided and to ensure patients and carers are well supported.

Northumberland Health Medical Practice
Kent and Medway NHS and Social Care Partnership
South East Health Limited
BPAS
Marie Stopes
Continuing Care Portfolio

Mental Health Cost Per Case Portfolio

Patients currently placed out of borough are being brought back to local accommodation, preferably within the existing Block Contract with Oxleas, or to suitable private sector local provision. We have reviewed our local residential strategy in order support this work. At the start of the process 14 out of borough placements were identified by the team attending the Residential Models meeting.

In September 2012, four patients have moved resulting in a contribution of £240,349 towards the forecast of £325,349, four will moved by the end of the current financial year, and four are long-term placements.
We will continue to work with Oxleas to ensure that cost per case placements are kept to an absolute minimum. We are aiming to get to a position where we do not make any cost per case placements at all.

There is also a proposal for three year agreement to protect children’s mental health services from the impact of Oxleas QIPP by focusing solely on an adult services QIPP.

**Learning Disability Cost Per Case Portfolio**

We have got 2 cost per case clients. Currently we are working within the residential models group with Oxleas to return these 2 clients to services in Bexley by December 2012.

**8.0 Timetable**

The draft timetable is set out at Appendix 1. It is based on the joint timetable developed with CSS and sets out key milestones.
<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRAFT COMMISSIONING INTENTIONS PRODUCED</td>
<td>30th September</td>
</tr>
<tr>
<td>AGREE WITH CSS SIGNIFICANT CHANGES TO CONTRACTS</td>
<td>30th September</td>
</tr>
<tr>
<td>ISSUE ANY SIX MONTH NOTICE PROVIDER LETTERS</td>
<td>30th September</td>
</tr>
<tr>
<td>CONTRACT NOVATION AND DEROGATION COMPLETE</td>
<td>minor elements to complete only</td>
</tr>
<tr>
<td>RISK ASSESS/CATEGORISE PUBLIC HEALTH CONTRACTS</td>
<td>5th October</td>
</tr>
<tr>
<td>ENGAGE LB BEXLEY IN PUBLIC HEALTH CONTRACT NEGOTIATIONS</td>
<td>Now - in Hand</td>
</tr>
<tr>
<td>COMMENCE GP AND PARTNER ENGAGEMENT AT LAUNCH EVENT</td>
<td>18th October</td>
</tr>
<tr>
<td>CONTRACT NEGOTIATION TEAMS ESTABLISHED</td>
<td>31st October</td>
</tr>
<tr>
<td>RECEIVE TRUST STRATEGIC AND PLANNING ASSUMPTIONS AND IMPACT OF CODING/ACTIVITY CHANGES</td>
<td>31st October</td>
</tr>
<tr>
<td>GROUND CLEARANCE FIRST MEETINGS WITH TRUSTS</td>
<td>31st October</td>
</tr>
<tr>
<td>AGREE ONGOING PROCESS OF CLINICAL AND PUBLIC ENGAGEMENT</td>
<td>18th November</td>
</tr>
<tr>
<td>NEGOTIATION STRATEGY FOR EACH PROVIDER Scoped</td>
<td>30th November</td>
</tr>
<tr>
<td>ACTIVITY, CQUINS, PATHWAY CHANGES</td>
<td>30th November</td>
</tr>
<tr>
<td>AGREE JOINT COMMISSIONING PRIORITIES AND SCOPE</td>
<td>30th November</td>
</tr>
<tr>
<td>WITH LBB AND ACROSS BBG AND SEL CCGs</td>
<td>30th November</td>
</tr>
<tr>
<td>LONDON-WIDE ASSUMPTIONS CLEAR</td>
<td>30th November</td>
</tr>
<tr>
<td>NATIONAL TARIFF GUIDANCE AND CCG ALLOCATIONS OUT</td>
<td>MID/END Dec</td>
</tr>
<tr>
<td>NATIONAL STANDARD CONTRACT REVISED</td>
<td>30th November</td>
</tr>
<tr>
<td>CCG AGREES ENVELOPES FOR EACH CONTRACT &amp; RESERVES</td>
<td>31st December</td>
</tr>
<tr>
<td>CONTRACT NEGOTIATIONS UNDERWAY</td>
<td>Jan/Feb 2013</td>
</tr>
<tr>
<td>EACH CONTRACT “PACKAGE” AGREED; PRICE; PERFORMANCE QUALITY</td>
<td>Mid-late Feb 2013</td>
</tr>
<tr>
<td>ARBITRATION PROESS AGREED WITH CONTRACTS TO BE ESCALATED; CONTRACT DOCUMENTATION ASSEMBLED FOR SIGN OFF.</td>
<td>Mid March 2013</td>
</tr>
<tr>
<td>CONTRACTS SIGNED</td>
<td>31st March 2013</td>
</tr>
</tbody>
</table>
Background

The development of Bexley CCG presents us with the opportunity to enable clinicians to lead the transformational change in the way services are delivered that will produce improvements in outcomes and meet the needs of the people of Bexley whilst delivering them within resources available.

Bexley CCG, following a refresh of the JSNA has identified a number of key areas that it wishes to prioritise as areas for step change and transformation in 2013-14.

At the centre of the transformation programme is the overriding aim to integrate all aspects of QIPP principles into each workstream. The programme will provide quality, innovative, productive services that look at whole system pathways including prevention.

A critical success factor of the programme is integration of services across organisation boundaries. The need to integrate services within Bexley has been a key priority for some years and in 13-14 is something that we will aim to deliver as a fundamental part of transformation.
Principles of Transformation

To achieve transformation we will work to a set of principles:-

1. Ensure linkages at a patient management level between the six priority areas and the wider system are standardised, accessible and responsive for patients
2. Develop system based and disease specific pathways from prevention and identification to end of life;
3. Breaking down of boundaries between primary, community, acute and social care
4. Development of innovative workforce solutions including federated GP working, joint health and social care teams, and greater partnership working between primary care and acute care clinicians
5. Commissioning of redesigned services to follow standard commissioning cycle and to ensure all appropriate procurement and contractual options and levers are assessed.
6. Patient involvement and engagement will be integral and will follow the CCG policy on patient engagement and involvement

Priorities

Six key areas have been identified for transformation:-

- Services for older people
- People with long term conditions
- Unscheduled care
- Planned care
- Mental health
- Children's services
Services for older people

(i) Where we are now

We have developed a joint integrated model of care with London Borough of Bexley which aligns to principles of the agreed Community Based Care Programme originating from the TSA work. A business case will be presented by the end of November. Underpinning this, are a number of workstreams that will form the older people work plan over the next 18 months.

(ii) Areas for transformation

- **Community Geriatrician model** – use of traditionally acute based expertise, to support patients in the community, breaking down organisational boundaries to contribute expert advice to multi disciplinary teams so building confidence in the system as a whole. This is integral to the overall model for elderly care and is expected to pilot in winter 2012-13. **Benefits** - reduced admissions from care homes to hospital, reduced readmissions rates from reablement into hospital, reduced lengths of stay for intermediate care beds and provision of clinical expert advice to GPs and community services

- **Case management** – GP led model of an integrated multi disciplinary team approach using innovative models of communication, to planning care for patients with complex needs, and monitoring outcomes. **Benefits** - improved quality of care for Patients, avoidance of admissions to care homes and hospital and improved medicine management

- **Multi agency discharge** – breaking down organisation barriers and ensuring flexibility in the approach to safe hospital discharge across the system. **Benefits** - patients be discharged from hospital once declared medically fit

- **Redesign of intermediate care** – provision of 24 hour reduced admission length, bedded support to the whole model of care by commissioning a limited capacity of beds to challenge traditional methods of care by enabling community based teams to care for patients in their own home. **Benefits** - Enables patients to not make a decision about long term care from a hospital bed and reduction in length of stay in hospital

- **Integration of reablement and community rehab** – An integrated model of delivering community based rehabilitation and reablement providing more streamlined, integrated working by sharing of skills and challenging traditional ways of working and providing efficient use of services. **Benefits** - improved quality of care resulting in one decision, one care plan

- **Redesign of service provided to care homes** – development of 24 hour based model of care including access to GP and community services, with a view to developing a virtual practice and support team to deliver care to Bexley homes including the improvement of nutrition in care homes. **Benefits** – reduction in admissions from care homes, improved care for residents
(iii) Challenges

- Ability to decommission activity and close beds
- Culture change in staff
- Integrated IT system
- Managing patient expectations in receiving care in the community rather than hospital setting
- Ability to quantify system wide benefits in the short term
- Obtaining buy in from GPs to change the way service to care homes is provided

(iv) Delivery plan

- Community Geriatrician model – agreement of specification, pilot over winter 2012-13, evaluate pilot and commission as appropriate
- Case management – evaluate pilot, business case to roll out to all practices, implementation by winter 2013
- Multi agency discharge – define need and service specification in partnership with LBB and commence service April 2013
- Redesign of intermediate care – re-specify intermediate care and reablement bedded facilities, procurement of new service to commence September 2013
- Integration of reablement and community rehab – redefine services and management structure in partnership with LBB and Oxleas, new structure to commence April 2013
- Primary care support to care homes – analysis of budgets and activity, scoping new model, commissioning of service

People with long term conditions

(i) Where we are now

We have undertaken individual service specific changes within individual disease pathways. In order to achieve whole system change we need to ensure we have disease specific outcomes and system based pathways to underpin appropriate use of unscheduled care and planned care.

Work is underway to develop specifications with commissioning colleagues in neighbouring boroughs in relation to MSK, cardiology and diabetes. A business case is going forward to develop a neuro-disability rehab service. A new anticoagulation service is set to start in January 2013

(ii) Areas for transformation

Long terms conditions management features in all the identified priority areas and in order to transform the delivery of long term conditions care, the other priority areas need to incorporate elements of long term conditions transformation.
In commissioning long term conditions care and management, transformational levers will be considered in the development of every pathway such as AQP, prime contractor models, partnership working and technological solutions.

Prevention and self care play a key role in reducing prevalence and managing long term conditions and this will be enhanced in the delivery of new pathways.

Areas identified to take forward are:-

- **Diabetes** – Working in partnership with Bromley and Greenwich to develop a comprehensive model of care across the four tiers of service, bringing consultant diabetologists into the community to support primary and community care as part of multi disciplinary teams working across the system, only returning to hospital based care for complex patients such as children with diabetes and gestational diabetes. **Benefits** – patients receive care in most appropriate setting, reduction in emergency admissions

- **Cardiology** – the commissioning of an integrated cardiology service encompassing detection of cardiological problems in primary care, community based diagnostics, chest pain clinics, consultant clinics, nurse led heart failure services, cardiac rehabilitation and inpatient elective services. This is an example of a complete disease specific system based pathway. **Benefits** – fast, accessible access to services, reduction in duplication of tests, seamless pathway, agreed budget envelope

- **Anticoagulation** – Implementation of a warfarin initiation and monitoring service across BBG offered on an AQP basis with Providers taking responsibility for partnership with secondary care for complex cases. This service will link also to the cardiology service to accept direct referrals and enhance the pathway. **Benefits** – AQP process offering choice of Providers and locations

- **Musculoskeletal** – working in partnership with Greenwich to develop a prime contractor model incorporating MSK triage, physiotherapy service, CATS, diagnostics and outpatient appointments and procedures. **Benefits** – patients will receive most appropriate care, reduction in outpatients, supports planned care initiatives of consultant advice and community diagnostics

- **Neuro-disability** – development of an integrated community based model of specialist rehabilitation, combining previous stroke rehabilitation services and traditional hospital based neuro-disability rehab services, again with responsibility for any acute based rehabilitation sitting with community rehabilitation providers. **Benefits** – increased rehabilitation available in community and home based settings, focussed, specialised support to patient group, responsible for inpatient care sits with community Provider

- **Respiratory** – Provision of system based approach for the management of COPD and asthma to include prevention and early identification, increased integrated care and supported self management, and post admission follow up integrated into long term condition management in primary care. This presents an opportunity to reduce organisational barriers by using specialist acute care support in the community. Ambulatory care will also play a key role in the system management of these patients. **Benefits** – reduction in non elective admissions, increased support from primary care, multidisciplinary support

- **Self care** – Provision of group education sessions and peer support for those living with long term conditions

- **Risk stratification** – the review of other models of risk stratification to identify additional cohorts of patients at risk of emergency attendances/admissions as result of their long term condition

- **Prevention - Adult and Childhood Obesity** – Sue TD to complete

- **Palliative care** – Further discussion required with Winnie Kwan GP lead to ensure comprehensive equitable palliative care treatment for patients and embed it within other priority areas
(iii) Challenges

- Integration of LTC conditions pathways into other priority areas
- Promoting changes in the primary care management and support of long term conditions
- Promoting self care among the general population of Bexley
- Accessing high quality data to understand current cost of long term conditions

(iv) Delivery plan

- Overall – development of new enhanced approach to GP delivered care for patients with long term conditions, mapping and incorporation of long term conditions care within other priority areas
- Diabetes – *Penny to complete*
- Cardiology – modelling, business case, commissioning process
- Anticoagulation – contracts, mobilisation
- Musculoskeletal – data analysis and modelling, business case and commissioning process
- Neuro-disability – procurement, contracts, mobilisation
- Respiratory – data analysis, scoping, ideas generation, review of NHS evidence pathways to assess suitability for incorporation, commissioning process
- Self care – scoping, GP development, ideas generation
- Risk stratification – review and analysis of different tools, pilot with GPs
- Prevention – *Sue TD*
- Palliative care – *info required from GP lead*

Unscheduled care

(i) Where we are now

There are currently a range of access points to unscheduled care. Patients have a choice of Urgent Care Centres at Queen Marys, Queen Elizabeth and Darent Valley, a walk in centre in Crayford, a minor injuries unit in Erith and the GP out of hours service. Access and guidance for patients is due to change imminently upon commencement of the 111 service in South East London. This will necessitate a review of current provision.
(ii) Areas for transformation

- Reduction of access points and direction of patients using 111 – review of access points in North Bexley to streamline care
- Redesign GP out of hours service to meet needs of other priority workstreams including provision of visiting service out of hours to care homes, support to palliative care pathway, combining with Urgent Care Services

- Sue R to add in terms of linking to elderly care pathways
- /Alan to add
- Dementia – Martin to add, please when completing show links to dementia priority
- Substance misuse/alcohol – Edwin/Julie T to add

(iii) Challenges

- Decommissioning current services and redirecting to alternative
- Ensuring Providers are not destabilised by commissioning changes

Sue R, Martin, Edwin, Julie T to add

(iv) Delivery plan

- Agreement with NCB and neighbouring CCGs on notice periods
- Analysis of data
- Business case and steps for disease specific areas
- Procurement, implementation

Planned care

(i) Where we are now

A range of services are offered in the community setting as an alternative to secondary care, including one stop dermatology, cardiology, and physiotherapy. Patients are booked in to these clinics by a Patient Management Centre that also currently triages a range of referrals for quality and suitability of a particular service. Enhanced diabetic services are also offered by Practices, trained to initiate insulin
(ii) Areas for transformation

- **Referral Management Centre** – the current Provider contract expires on the 31st March. This provides an opportunity to re-specify the service to increase the element of triage and increase scope of the service to cover areas such as A&E referrals, consultant to consultant requests that sit outside the contractual agreement and diagnostics. There may also be opportunity to require enhanced analysis to further interrogate referral activity and behaviour and inform future commissioning intentions. **Benefits** – ensures appropriateness of referrals, informs future redesign areas, gatekeeper for access to secondary care

- **Diagnostics** – Currently diagnostics sit within an outpatient tariff. From April 2013, the diagnostic element will be costed separately. This gives an opportunity to develop community based diagnostics in health hubs in Bexley. Specifically a locality based ultrasound service that supports a wide range of conditions should be explored. **Benefits** – close, easy access to diagnostics, supports redesign of services into community

- **Pathology** – Outsourcing of pathology services to independent Provider. A viable model to be considered for a BBG joint procurement of pathology. **Benefits** – removes IT problems currently faced in acute, estimated savings in region of 20% pathology budget

- **Consultant advice service** – many first outpatients appointment result in discharge. In areas where this is high such as trauma and orthopaedics, paediatrics, cardiology and ophthalmology, consultant advice services should be explored. In particular these should be incorporated into the long term conditions service pathways and linkages with mental health and children’s services should be developed. **Benefits** – reduction in outpatient spend, supports long term conditions pathway development

- **Day case surgery** – assessment of routine day case procedures for suitability to be performed in healthcare hubs. Evidence is available to support podiatry day case surgery removal from acute settings. **Benefits** – car closer to home, move away from tariff

- **Community Consultant Services** – review of consultant role in management of other priority areas including long term conditions and mental health to move care into community settings. **Benefits** – supports new models of care, provides care in most appropriate setting

**Other ideas to be developed by Neil Hayles**

(iii) Challenges

- Changing the mindset of acute staff to consider alternative styles and place of work
- Agreement across BBG CCGs
- Space to deliver community diagnostics
- Financial viability of procuring a Referral Management Centre
(iv) Delivery plan

- Referral Management Centre – options appraisal, and then if appropriate service specification, business case and commissioning process
- Diagnostics – analysis, ideas generation, specification, business case, and commissioning process
- Pathology – analysis, BBG agreement, ideas generation, specification, commissioning process
- Consultant advice service – stakeholder engagement, analysis of referrals, ideas generation form
- Day case surgery
- Community Consultant Services

Mental Health

Martin/Emma to complete

Where we are now

Areas for transformation

Challenges

Delivery plan
Children's services

Alison Rogers to complete

Where we are now

Areas for transformation

Challenges

Delivery plan

Enablers and Drivers

1. Strategic Drivers
   - National Outcomes Framework
   - Health and Social Care Act
   - NHS Improvement – COPD Saving three million lives
   - London Integrated Care Programme
   - JSNA
   - Health and Wellbeing Strategy
   - Commissioning Intentions Plan
2. Local Enablers

- **Resource** – Additional project management and analytics support will be required to deliver the programme.
- **Health Hub** – A hub/hubs in Bexley will be required to deliver significant aspects of the programme including intermediate care beds and community diagnostics.
- **GP development** – GPs will have a key role to plans in the detection and treatment of patients with long term conditions and at risk of admission. This will require a change in the current working practices.
- **Joint commissioning** – Many transformational areas require collaboration with London Borough of Bexley. Agreed joint commissioning arrangement will support this.
- **Integrated informatics system** – The accessibility and sharing of records across organisations is integral to the delivery of transformation care provision. Currently most systems are still in development and there are significant information governance issues to overcome.
- **Outcome based KPI’s** – A move away from traditional activity based KPIs towards quality outcomes enables Commissioners to contract for high quality services without the need for focussing on how the service is actually delivered, so allowing for innovation in Providers.
- **Multi CCG collaboration where appropriate** – Efficiencies will be gained in some transformational areas where CCG have similar priorities, to commission for the larger population.
- **Commissioner and Provider collaboration in the design of pathways and services** - clinical engagement and support of new pathways increases likelihood of success and enables a more integrated approach to care.

**Practical delivery mechanism for Transformational Change**

Each priority area requires an agreed process for delivery of transformation change. Common processes for delivery will be

1. **Strategic clinical and stakeholder roundtable groups for each priority area** comprising primary and secondary care clinicians, community and social care representatives where appropriate, patient representatives and senior management representatives of at least “Assistant Director” or “Head of Service” level to further develop priorities, oversee workstreams and assist in “unblocking blockages” in the system. Members will be responsible for reporting progress to their respective organisations.

2. **Project team** identified for each project consisting of, where appropriate, named project manager, patient representative, finance lead, data analysis lead, GP lead, acute, community and social care leads. Responsible for delivery of scheme.

3. **CCG Transformation Steering Group** consisting of Director of Commissioning, A/D Community and Primary Care Commissioning, A/D Acute Commissioning, A/D Children and Young People, finance/PMO rep? (membership to be agreed with MA/SB) to oversee Transformation Programme including ensuring appropriate synergies linkages and overlaps across the programme are identified and addressed.
Next Steps

- Identification of additional schemes (if required – this is already a large programme)
- Project leads identified for each area of work
- Work up of new schemes
- Agreement via PMO of schemes to take forward
- Additional resource requirement in terms of project management, analytics etc scoped
- Roundtable group meetings established
- Project plans developed
- Steering group formation