NHS
Surrey Downs
Clinical Commissioning Group

Commissioning Intentions 2016/17

Final – January 2016

Improving care together across Surrey Downs

Introduction

1. NHS Surrey Downs CCG issues each year, detailed Commissioning Intentions (CIs) to each of its contracted providers. These commissioning intentions reflects the CCG's plans for the following year to maintain or change current contracts and activity flows.

2. The CIs for 2016/17 have been drafted in the context of:

   - The CCG's Five Year Strategic Commissioning Plan 2014 – 19
   - The CCG's Financial Recovery Plan 2015 – 18 and associated directions from NHS England regarding the CCG's financial position

3. Input to developing these CIs have been:
   - Existing priority work areas, agreed in 2015/16 CIs and requiring ongoing development in 2016/17
   - Areas of variation in activity and cost versus statistical peers
   - Prioritisation exercises run with each of the CCG's three commissioning locality meetings
   - Public and patient feedback and engagement via a survey and gathered via comments and questions from events run by the CCG

4. This document is deliberately not detailed or exhaustive. The CCG has a comprehensive governance process for developing and assuring commissioning programmes. Each of the areas of work indicated in this document will be subject to the development of a Programme Initiation Document (PID), which is subject to scrutiny by a Programme Delivery Board, an assessment of its potential impacts on Quality, Equality and Privacy, and eventually, Executive Lead signoff. Assurance on this process is via the CCG's Finance and Performance Committee.

5. Domiciliary care contract r2016 as part of an integrated Operating Plan for 2016/17 which will deliver the CCG's objectives for the year in terms of quality, outcomes and financial recovery, the basis of which will be the PIDs outlined above.

6. CIs are divided into broad work areas for the CCG. In a number of areas the CCG commissions services on a collaborative basis with other CCGs, so the CIs reflect shared intentions between a number of CCGs

Planned Care

7. In 2015/16, the CCG has pursued as a priority, service redesign work in a number of planned care pathways. New referral thresholds and guidance have been implemented in orthopaedics, rheumatology and cardiology; a pilot model for managing musculoskeletal referrals is now underway, and a business case has been approved for reform of ophthalmology pathways to enhance the role of community optometry. GP practices now receive regular practice dashboards which show their relative rates of referral and planned care spend against other practices and their locality. The CCG's Referral Support Service has been improved and streamlined to ensure greater consistency in the management of referrals. Contracts with elective care providers have been reviewed and negotiated to ensure best value for money.

8. In 2016/17, the CCG will

   a. Complete the implementation of new models of care in musculoskeletal pathways, ophthalmology and cardiology. This will involve all of our contracted providers undertaking new approaches including enhanced primary care based provision, refocusing of existing services and redesign of internal processes, for example around the hospital-based treatment of Wet AMD.

   b. Mobilise new service models currently under design in ENT/Audiology, Dermatology and Gynaecology

   c. Commence new service redesign initiatives in Gastroenterology, Neurology and Urology.

9. The CCG will continue its approach of ensuring that wherever possible, outpatient based care is provided as close as possible to the patient, ensuring that new models make use of community and primary care facilities wherever possible. This is supported by the outcome of the community hospital services review.

10. Based on GP feedback, the CCG is considering the extension of the RSS to include the processing of all patients discharged from hospital with a request for GP to re-refer to a different hospital consultant, and the triage of all referrals made by A&E departments to other hospital departments. The RSS will continue to develop its advice and guidance role to enhance the support available to GPs in making appropriate referrals.

11. The CCG is also considering the introduction of a mechanism of prior approval for restricted procedures and treatments. This will not in itself change what the CCG chooses to fund, but will be aimed at improving compliance with the CCG's policies. This would be for a wider range of conditions than those covered by the existing Individual Funding Request (IFR) process.

12. The CCG will continue to work jointly with Macmillan to improve systems, processes and clinical skills in support of early detection of cancer and to identify opportunities to support those living with and beyond cancer. Acute commissioned activity for 2016/17 will reflect the additional capacity required to deliver new thresholds for cancer referral issued by the National Institute for Health and Clinical Excellence. Most Surrey Downs CCG patients receive all cancer treatment from London-based providers. The CCG will work with its GPs to implement pathway-specific referral guidance and proformas being developed by the London Transforming Cancer Services Team and will engage the cancer networks serving the south of the Surrey Downs catchment to ensure that any local pathway modifications are reflected.

Urgent care and integration

13. In 2015/16, the CCG delivered the establishment of Community Medical Teams (CMTs) in each locality, providing locality-based management of local community hospital beds and enhanced out of hospital care for those at highest risk of hospital admission. These teams have recently been augmented with a wider community hub workforce, delivered by CSH Surrey, creating a multi-disciplinary team able to manage patients with complex needs in the community setting.

14. The challenge of the integration agenda is that it necessarily requires the CCG to stand back from its traditional role of determining the optimal pathway of care for each presenting condition and then redesigning services to deliver that pathway. Our approach reflects the fact that patients who present at hospital with, for example, an exacerbation of Chronic Obstructive Pulmonary Disease, will often have a range of complex health and social care needs which current systems are not well adapted to support. Because our localities work each work with a slightly different set of partner agencies, for a plan to address this to be effective it needs to reflect the local context and most importantly be locally owned. This is why we have asked each locality to develop its own urgent care and integration transformation priorities for 2016/17.

15. In the Epsom locality, a partnership called Epsom Health and Care (EHC) has now been formally launched. Composed of the CCG, acute hospital trust, CSH Surrey, mental health trust, social care and primary care, EHC is now working to develop its shared plan for further integration of health and social care in the Epsom area, focusing on more proactive care of those at high risk of hospital admission and building on the pilot Community Assessment and Diagnostic Unit (CADU) which has recently opened at Epsom General Hospital.

16. East Elmbridge and Dorking localities are both working on developing their integration plans, building on the positive work to date.

17. We will expect that each locality's plans reflects:

    a. The CCG's approved End of Life Care strategy

    b. The need to share care plans and key clinical care records between health and social care providers to facilitate improved continuity of care.

    c. A move from a reactive approach – of GPs, hospitals and community staff identifying patients whose health has deteriorated and referring to CMTs/Community Hubs – to a proactive approach of using risk stratification tools and local knowledge to identify the patients at highest risk of deterioration and actively intervening to support those patients

    d. Maximising the potential of the CCG's community hospitals to provide 'step-up' care – currently 95% of admissions are 'step down' from the acute setting

18. The CCG will shortly move to formal consultation on the outcome of the community hospital services review undertaken in 2015/16. The Governing Body will consider the outcome of the consultation prior to considering whether changes to the structure of inpatient rehabilitation services will be made in the first quarter of 2016/17.

19. The Surrey Collaborative comprised of the six Surrey CCGs is working to transform the stroke pathway across Surrey. The programme of work has identified what 'good' looks like for stroke care across the whole pathway. The expected result of this comprehensive review is that stroke services will be commissioned that deliver a high quality pathway for all. This will involve reconfiguring acute care so specialist services for hyper acute care are delivered by three hospitals in Surrey. This will ensure that appropriate clinically safe volumes (at least 600 plus per annum) of patients suffering a stroke receive care in a specialist unit in line with national guidelines and best practice. The delivery of

this expert care for stroke patients, and the related staffing levels required to deliver the revised model of care, will be in accordance with the national and South East Coast service specification.

Children's and Young People's Services

20. In 2015/16 the CCG, working with the other Surrey CCGs, re-procured its Child and Adolescent Mental Health Services.

21. The focus of 2016/17 will be on working with other Surrey CCGs to confirm the extent of Surrey Downs' involvement in the Surrey-wide reprocurement of children's services. A key part of this will be improving our understanding of need, gaps and service redesign required to meet the needs of children a range of needs including those with the most complex healthcare needs. This will include:

    a. Improving access to speech and language therapy, working with CSH Surrey to implement the joint commissioning principles agreed Surrey County Council in 2015 to improve the lifetime outcomes for children with speech, language and communication needs

    b. Improving access to evidenced based occupational therapy; Surrey CCGs will focus on early intervention and support for children with physical disabilities, in partnership and joint commissioning with Surrey County Council to improve lifetime outcomes for children;

    c. Clarifying service design for children community nursing services and moving to a single Surrey-wide specification

    d. Understanding our service challenges and solution for supporting an increasing number of babies, children and young people with continuing and complex healthcare needs; including implementation of any revision guidance for children with continuing healthcare;

    e. Ensuring women are able to make safe and appropriate choices of maternity care for them and their babies

Mental Health Services

22. Based on GP and recent feedback from both mental health and hospital providers, the CCG will review the arrangements for psychiatric liaison services at each of its main hospital sites, with a focus on those provided in support of Epsom General Hospital where the CCG is the lead commissioner.

23. The CCG will work with the Mental Health Collaborative on the re-procurement of Improving Access to Psychological Therapies (IAPT) services, with increased quality uplifts against the current contract. This will include targeting IAPT for carers and the elderly and embedding the self referral system currently being put in place.

24. [Further CIs awaited from NEHF leads]

Medicines Optimisation

25. The CCG has seen continued improvements in its medicines optimization approach for a number of years, including the introduction of locality-level prescribing budgets. In 2015/16 the CCG will support the further development of the team's role, to include:

    a. Supporting GPs to optimize the identification and management of patients with Atrial Fibrillation with a focus on increasing the uptake of anticoagulation therapy where appropriate

    b. Medication review and support for frail elderly patients (including care homes), including the deployment of a medicines management dietician

    c. Support improvements in prescribing for asthma, COPD and diabetes

    d. Tackle medicines related problems through improved medication review, medicines reconciliation and post-discharge support

    e. Work with Epsom and St Helier hospitals to improve outpatient process around repeat prescribing of hospital only drugs and apply learning to other sites

26. The CCG continues to host a strong Strategic Pharmaceutical Commissioning team whose focus for 2016/17 will be on ensuring the prompt uptake of biosimilar alternatives to expensive biological therapies for inflammatory conditions, and working with the planned care team to optimize the management of Wet AMD in Ophthalmology.

Continuing Health Care

27. The CCG continues to host the Continuing Health Care function across Surrey CCGs. These intentions therefore reflect the work programme shared across the Surrey collaborative:

    a. Deliver the quality in care homes project – Surrey-wide re-procurement of high cost low volume providers

    b. NHS Care Home Contract review

    c. Domiciliary care contract review

    d. Paperless CHC function implementation

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