Attachement 2 - NHS Herefordshire CCG -DRAFT COMMISSIONING INTENTIONS for CONSULTATION - Version 0.1

CCG Work Programme	Area	Draft Commissioning Schemes	Relevant provider (s)
Childrens	Children with disabilities	Development of a joint commissioning plan with Herefordshire Council to include: •Integrated pathway moving from pre-birth to transition into adulthood. Inc. Autism pathway •Commissioning direct services (including respite fostering) to support children with disabilities in family settings rather than requiring residential care •Commissioning of post 19 opportunities to support young people in local education and training •End of life pathway for Children and young people •Continuation of the implementation of the Herefordshire Transition protocol for children with long-term conditions. •Continuing the redesign of short breaks provision •Continuing development operational arrangements for integrated education, health and social care plans and reviews. •Increasing use of personal health budgets. •To progress the recommendations arising from the 2015/16 review of community health services for children	All providers and Commissioners
Childrens	Emotional Health and Wellbeing	•Improvements to Perinatal mental health provision •Enhancement of community eating disorders service •Revised Crisis Care pathway and 24/7 assessments •CAMHS/ GP/ School Link (tier 1 and 2 improvement) •Sustainability of CYP engagement and participation •Roll out of ROM (reported outcome measures) across CAMHs and making better use of technology •Increase in tier 2 capacity, e.g. primary mental health / CYP-IAPT. •Delivery of CYP-IAPT programme (continuation of staff training) •Improvement against compliance of WMQRS standards for CAMHS	All providers and Commissioners
Childrens	Safeguarding	•Joint Commissioning with Herefordshire Council to meet the needs of looked after children – e.g. care placement strategy, fostering framework and potential regional framework approach. •To improve the arrangements for Designated Doctor, with increased sessions.	All providers and Commissioners
Childrens	Maternity Services	•To seek improvement to local maternity services including Early Booking, access to patient records, midwifery-led unit, pathways; perinatal parental mental health; recording and reporting.	WVT NHST and 2gther Foundation Trust
High Quality Clinical Services	Stroke	•Continue to implement outcomes of the Stroke Review across the whole pathway including Stroke Prevention in AF, a networked approach to a fully serviced HASU/ASU, greater use of early supported discharge, through to work with stroke survivors to improve quality of care for stroke patients and delivery of national TIA standards	WVT NHST
High Quality Clinical Services	Education	•Co-ordinated education programme for clinicians, and other key stakeholders, to support pathway and redesign development	All providers
Integrated Care	Community Services	•To redesign adult bed based community services in order to improve clinical outcomes and deliver a clinically sustainable and financially viable model of services that Maximises independence and self-management, provides choice and control over the services that individuals receive and reduces emergency admissions and facilitates timely hospital discharge	WVT NHST

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Integrated Care	Dementia	As part of the dementia partnership: •Increase availability of early diagnosis of dementia and support (inc delivery of national dementia standards) •Support people with dementia, carers and families to live with dementia •Drive a Herefordshire wide culture change through awareness and understanding •To review the community dementia service in terms of activity and demand •To continue to promote dementia and support identification of people requiring diagnosis	All providers
Integrated Care	Better Exploitation of Information & Technology	Working with partners to exploit IMT to support delivery of CCGs and systems vision to include: •Ensuring access to the right information, in the right place at the right time •Using technology to support best clinical practice, moving to paperless working, this facilitating service efficiency, effectiveness and safety •Enabling care to be brought to the individual, rather than individuals travelling too far to receive care	All providers
Integrated Care	Care Coordination & Local Directory of Services	•a single point of contact for clinicians and health practitioners wishing to access acute or specific community services or alternative assessment pathways for those with physical health or care needs, moving to inclusion of mental health support services during 16/17 • To actively divert admissions from acute ED where appropriate, leading to a reduction in overall admissions. • To maintain an up to date directory of local services • To assist in effective assignment of community hospital and reablement beds, including the repatriation of patients from acute providers out of county •To maximise the utilisation of alternative community services and consistently identify the most relevant service. •To facilitate safe discharges and transfers with good quality handover information to a service that meets the holistic needs of the patient. • Identify mechanism for public access to support and advice	All providers
Integrated Care	Managing the Care home market	As part of the Better Care Programme develop integrated and improved working across health and social care, where people receiving housing with care will receive cost-effective, personalised support that enables them to be independent as long as possible including seamless assessments and improved experience of care. Will include assessment of market and new care home market strategy.	All providers
Medicines Optimization	Joint Formulary and local Herefordshire or/and national guidelines	• Pharmaceutical service providers must supply medicines approved within the local Herefordshire joint formulary and forward or advise on requests for non approved medicines to appropriate agencies. • Providers must ensure all medicines use and prescribing is in line with the agreed Herefordshire Joint Formulary and local Herefordshire or/and national guidelines e.g. NICE and policies	WVT NHST

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Medicines Optimization	medicines optimisation contracts and minimum standards	•All community inpatient facilities must have a minimum of one clinical pharmacist visit per week. •All community hospitals must hold controlled drugs stocks as per locally annually agreed site stock lists to enable 24/7 patient access, reduce waste resources e.g. medicines costs and the need for witnessed CD destructions. •Home Office Licence should be held by relevant provider sites to ensure that Controlled Drugs can be provided, transported, stored, monitored closely to ensure equitable access to medicines across sites for all patients e.g. all community hospital sites •Pharmaceutical service providers must ensure systems are in place to assure all community and provider services dealing with	All providers
Medicines Optimization	medicines governance	• Pharmaceutical service providers must work within the relevant sections of the Herefordshire CCG Medicines Management Quality Schedule 2014/15/16. • Pharmaceutical service providers must ensure systems are in place to assure all community and provider services dealing with medicines have appropriate pharmaceutical advice and support including appropriate skill mix support. • Providers must ensure compliance with legal and statutory requirements and good practice where medicines are supplied i.e. • Wholesale dealers licenses •Home office licenses for controlled drugs •under patient group directions and/or non-medical prescribing and support for systems and staff.	All providers
Medicines Optimization	Information Technology and Medicines (Secondary Care)	Providers of secondary care services involving medicines are: · encouraged to adopt e-prescribing as part of wider patient safety initiatives · utilise electronic database and scheduling to proactively manage patient outcomes and costs of key High Cost Drugs e.g. biologics in rheumatology and ophthalmology · expected to supply Electronic Patient Records for medicines on discharge to GPs and in the future community pharmacies	All providers
Medicines Optimization	Information Technology and Medicines (primary	Providers of primary care services involving medicines are expected to: · Enable and substantially increase the percentage of Patients accessing online repeat prescriptions ordering through secure IT portals e.g. EMIS Patient Access.	All providers
Medicines Optimization	Information Technology and Medicines (all providers)	Locally commissioned services from any qualified provider involving medicines should record electronically: medicines supplied , service implementation parameters , patient outcomes, exception reports, enable patient recall, invoicing/claims to facilitate performance monitoring by the Commissioner.	All providers

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Medicines Optimization	Medicines Optimisation Service Redesign (WVT)	Specifically for 15-16: 1. Community hospitals all including NHS and NHS commissioned minimum standards to apply across all 2. NHS community based stoma nurse service – continue to implement service re-design in line with contract details : a) Implement additional EMIS Web IT functionality to support patient record management , b) integration with practice information and undertake non- medical prescribing of community stoma patient appliance and devices. 3. Wound management a) District Nursing support dressing supply and leg ulcer management primary care b) TVN support for primary care including care homes 4. Anticoagulation community service clinics to move to point of care testing for all patients including i.e. housebound and potentially 5. Pathology/haematology to professionally support point of care testing for primary care commissioned services e.g. web based quality assurance 6. Rheumatology gain sharing agreement- details integrated into main points	All providers
Medicines Optimization	Medicines Optimisation Service Redesign (2g)	2g must ensure all medicines use and prescribing is in line with the agreed Herefordshire Joint Formulary and local Herefordshire or/and national guidelines e.g. NICE and local prescribing focus i.e. quetiapine MR venlafaxine MR	2gether Foundation Trust
Integrated care (Learning Disabilities)	Learning Disability	•Develop a shared strategy for Learning disabilities Inc. Promote wellbeing and healthy lifestyles, supporting access to employment, extending choice and control over care and support and better understanding need, and strengthening pathways between primary and community care •Deliver an outcomes based procurement of agreed areas of the pathway as part of the mental health re-procurement process •Implementation of autism strategy Deliver continuous improvement in response to Winterbourne Review and out of county placements	All providers
Modernising Mental Health	Mental health	•Jointly commissioned re-procurement of Mental Health services during 2015/16 to commence April 2017 •Agree and implement whole system mental health strategy and ensuring parity of esteem of Mental Health with physical health •Delivery of Crisis Care Concordat - 24/7; information & advice; crisis care planning; crisis care pathways • Improve early access intervention for psychosis • Improved mental health care pathways • Ensure access to psychological therapies is improved and NHS England targets are met • Review access and criteria for rehabilitation to improve the provision of recovery services, long-term treatment and care available within the county, with the outcome of more people regaining independent living skills and continued repatriation of patients •Seek system-wide approach to aid the early identification of those people in greatest need or risk of developing a mental health condition •Continuation of improvement to care planning for all people using secondary mental health services	2gther Foundation Trust

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Planned Care	Cancer	•Ensure compliance with NHS constitutional commitments and standards (2 week aits, 31 and 62 days) & delivery of Strategic Clinical Network priorities for local cancer care to achieve better outcome for people living with and beyond cancer. • Local Herefordshire Cancer work programme/strategy drafted, to be agreed with partners, patients and public, supported by a clear implementation and evaluation plan • Survivorship and prevention at heart of the cancer strategy and programme	WVT NHST and Gloucestershire Hospitals
Planned Care	Demand management	•E-referral - continue to develop work programme and ensure implementation of a single electronic referral process across all specialities, underpinned by agreed pathways of care •Diagnostics - Improved rapid access to diagnostic tests ensuring that NHS organisations are delivering a maximum wait of 6 weeks for tests across all specialities •Focus on demand management by specialities including review of adherence to low priority treatment policy and measures to improve new to follow-up ratio	Primary Care and WVT NHST
Planned Care/Integrated Care	End of life	Improve palliative and end of life care pathways, for Children, Young People, Adults, and Older People, including: •Increased identification of end of life needs – Gold Standard Framework surprise question •Person centred end of life care plans (including advance care plans) •Whole system EoL & Palliative Care coordination •Virtual Hospice; whole system EoL care •Consistent educational model for EOL care for whole health & care economy (Inc. Care homes, WMAS, GPs, Domiciliary Care Agencies)	All providers
Planned Care/Integrated Care	Management of LTCs	•Supported self-management: continued development of patient held records and self-management plans (Inc. roll out and development of risk stratification systems, processes and tools) •Implementation of LTC strategy with focus on improved supported self care and reduction in unscheduled admissions and readmissions	All providers
Planned Care/Integrated Care	Cardiovascular disease	•CVD: collaborate with partners to deliver Herefordshire action plan that underpins the County's CVD outcomes strategy. To include commissioning of integrated Familial Hypercholesterolemia for Hereford and Worcester and Implementation of National Diabetes Prevention Programme	All providers
Preventing Ill-health and improving health	Healthy Lifestyles	•Work with key partners, including Hereford Council Public Health, to improve and promote smoking cessation services and alcohol abuse services to promote healthier lifestyles •Embed MECC into every consultation and contact with people in appropriate settings and within the educational programme •Support education across primary, secondary care and care homes • Obesity - A whole pathway approach to Obesity prevention and management. Joint working with LA implement an integrated Pathway for Adults, Young People and children.	All providers
Preventing Ill-health and improving health	Personal Health Budgets	•Enhance use and availability of personal health budgets in line with national requirements	All providers

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Primary Care	Primary Care	• Develop the Herefordshire CCG primary care strategy and implementation plan (including stakeholder and GP input) • Deliver a robust primary care development and Education Programme 2015/16 • Undertake effective Practice Engagement and Communications programme • Produce a Primary Care Estate Strategy •Establish a Primary Care IM&T strategy underpinned with clear information governance •Work with the SRG to deliver Primary Care Service Resilience •Develop a model for seven day working including access to urgent care services.	Primary Care
Putting Patients at the heart of Everything we do	All programmes	• Seek opportunities to improve the extent of participation by patient and carers in shaping and evaluation of care pathways so that people understand the role they can take in their own health and health care • Work with HeathWatch to develop a systematic approach to patient and public engagement to establish effective sustainable processes that ensure patient and public views are considered in the steps of service re-design • Harness opportunities to work with Herefordshire Carers Support to help embed and evaluate local care pathways and referral processes (e.g. Heart Failure support group) • Children and young peoples experiences are collated and shared with commissioners	All providers
Urgent Care/integrated care	Urgent Care	•Continuation of Outcomes based commissioning and contracting of a whole system community focused urgent care pathway •Review, evaluate and reform the Urgent Care pathway focusing on acute care, intermediate care, community health and social care services. •Re-commission Community Teams as a single integrated resource and evaluate the county-wide roll-out of community teams, integrated care practitioners and implementation of RAAC •Explore 7 day primary care working to deliver community point of contact for minor urgent healthcare need •Redesign paediatric emergency and urgent care pathway. •Develop a model for seven day Primary Care working including access to urgent care services. •Primary Care service to work seamlessly with in hours 7 day Primary Care developments.	All providers