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Commissioning Intentions 2014/15

Hammersmith & Fulham Clinical Commissioning Group

& the London Borough of Hammersmith & Fulham

Chair's foreword

[DN – further content to follow]

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1. Executive summary

This document outlines the commissioning intentions for NHS Hammersmith and Fulham CCG for 2014/15 and builds on the commissioning plans implemented in 2013/14. These intentions reflect the 2014/15 implementation of Shaping a Healthier Future (SaHF), the CCG's longer term strategic vision, its commitment to commissioning for quality and the medium term financial strategy. They also set out the areas where we wish to contract differently, improve quality or transform service delivery. There is further information which sets out our strategy in Sections 1 and 2 of this document.

2014/15 will be the first full year for implementing our health care transformation programme in NW London, SaHF, which sees the creation of five major acute hospitals and unprecedented investment in Out of Hospital services. The CIs across CWHHE reflect the scale and pace of this ambition.

The challenge facing the NHS over the next 5 years is immense. Annual growth in NHS resource is lower than it has been for a decade, demand for services is increasing and, with the creation of the Integration Fund, the need to work jointly across the health and social care system is made explicit while also representing a substantial financial threat to the NHS if integration is not achieved. This challenge cannot be met with more of the same, or through incremental change around the edges of NHS services. In these commissioning intentions we seek to make widespread, transformational change across our health and social care system to deliver a step change in the quality of services and the experience of patients while enabling the system to remain financially viable. We expect the providers of the services we commission to respond to the changes we are seeking to make.

As part of this we expect that we will be commissioning Whole Systems Integrated Care in shadow form for parts of our population and we will be working ever more closely with our LA partners to do this.

To signify this deepening relationship the commissioning intentions for the community and mental health trusts are written jointly by the CCG and the London Borough of Hammersmith and Fulham and cover the services that we both commission from these providers. These are set out in section 5.

The commissioning intentions are written at two levels. At a strategic level they provide a consistent and coherent framework across the Tri-borough, Hounslow [and Ealing] health systems and at a local level they set out the detailed service changes that reflect the strategy for each health economy.

The table below summarises the commissioning intentions and the provider sectors which they affect, and demonstrates the linkage between those commissioning intentions and the CCG's strategy.

How we work

In April 2012, the CCGs of Central London, West London, Hammersmith & Fulham, and Hounslow formed a collaborative to share a leadership team and work together on areas to enable them to become effective commissioners. Ealing CCG decided to join the Collaborative from November 2013 and, collectively, we are known as CWHHE.

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The decision to collaborate was reached because the CCG's felt that this configuration would best:

- Enable each CCG to tackle cross Borough issues and give the maximum influence over decisions that span multiple CCGs such as Trust FT applications or the ongoing negotiation and management of contracts with key providers
- Enable CCGs to influence the shape of the provider landscape in NW London
- Facilitate the work required to ensure financial viability of the NW London Health system
- Enable the CCGs to achieve economies of scale and attract talented individuals to the key leadership roles in NWL CCG Executive structures
- Enable the CCGs to manage the performance of the Commissioning Support Service.

Principles and model for collaboration

CCGs are membership organisations so the ways of working across the CCGs should enable the members to have a lead on all decisions. In practice this could mean that members agree with Chairs the parameters of decision making that the Chairs are delegated by the members to take on their behalf. Therefore decision making does not become an onerous task which requires extensive forums and complicated governance and process. Chairs will be able to delegate authority to individuals in a CCG that can make decisions on their behalf.

The collaborative organisation works to the following principles:

- Recognising the sovereignty of the CCGs and that CCGs are membership organisations
- Working as a collaborative when we can demonstrate that it will best serve the patients of the individual CCGs
- Having strong clinical leadership drawn from the CCGs and their Governing Bodies
- Demonstrating subsidiarity with the majority of decisions being made by the CCG members.
- Having governance arrangements, such as succession planning and delegation procedures, that facilitate continuous and timely decision making
- The collaborative does not create an additional performance management structure in the system.

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	Strategic fit						Provider sectors impacted					
Commissioning Intention	SAHF	OOH strategy	JSNA	H&WB strategy	Mandate	National priorities	Primary care	Community	Mental Health	Acute	Continuing care	Voluntary sector
Integrated care and community services	✓	✓	✓	✓			✓	✓		✓		
Integration Fund	✓	✓	✓	✓				✓		✓		
Urgent and emergency care	✓	✓	✓				✓			✓		
Primary care	✓	✓	✓					✓		✓		
Nursing and residential care						✓	✓					
Planned care												
Cancer			✓									
Mental health			✓									
Learning disabilities												
Children's services				✓								
Services for carers												
Public health			✓	✓								

[DN – further cross checks to be completed on this table]

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2. Strategic contracting principles and intentions

We have a number of strategic principles and contracting intentions that are consistent across all providers and which will form the basis of our contracting approach for 2014/15. These are set out below.

Strategic contracting principles:

We expect all providers to:

- Be working towards the implementation of SaHF, and delivering on the key changes required such as the implementation of the service standards and the improvements in efficiency and length of stay
- Work with us to integrate services across the patient pathway to ensure that patients experience seamless health and social care services
- Move towards a single patient record through the implementation of new systems that are compatible with the GP IT system or through ensuring intraoperability of existing systems with the GP IT system
- Demonstrate continuous improvement in the quality of the services they are providing to patients encompassing patient safety, clinical effectiveness and patient experience
- Have in place and to demonstrate robust systems and processes for safeguarding children and adults and to ensure embedded learning from Winterbourne View and the Robert Francis Inquiry
- Demonstrate robust systems for equality, diversity and inclusion.
- Work with us to reduce non elective admissions to hospital through better management of patients in the community and improved patient pathways within A&E
- Work with us to upstream care so that we move from a model of reactive unplanned care to planned care for the treatment of long term conditions
- Ensure that activity that has been decommissioned as part of QIPP schemes is discontinued, with appropriate reductions in capacity, and to actively work with CCGs to safely transfer patients to the alternative services
- demonstrate that they have systems to capture, collate, interpret and understand the implications of patient and public feedback and that they are implementing changes and improving services based on that feedback
- Demonstrate how they are monitoring the equalities profile of their service users and examining what that information tells them about cohorts that are over or under-represented in their services
- Work with the CCG to ensure that patient experience is used to inform the provision of services that are compassionate, safe, effective and responsive to meet the clinical, social and personal needs of patients, carers and the wider public

- Actively engage with their staff to enable them to embed the NHS England's '6Cs' into ways of working with patients, relative and their supporters. The 6Cs are: care, compassion, competence, communication, courage and commitment

- Design services around the patient to avoid unnecessary multiple trips to hospital, particularly for specialist diagnostics and opinions. This should also be cost releasing

- Provide alternative models of care that enable GPs to gain rapid access to consultant expertise through hotlines, emails or other technology

- Prioritise prevention, health promotion and the reduction of health inequalities by embedding them into service delivery and referring as appropriate into local public health, community and voluntary services.

Contracting intentions to apply to all providers:

- We will only pay for acute services based on SUS data for those services reported through SUS

- We will not pay for internally generated demand where there is a primary or community service that could better manage the care of the patient or where the pathway generated by the internal referral does not make sense for the patient

- Our local CQUINs will be focused on delivering real, innovative service transformation to improve outcomes for patients

- We expect all providers to be achieving at least upper quartile performance across a range of benchmarked indicators

- If patients are admitted to hospital then the GP should be informed within 24 hours and will be directly involved in the discharge planning for the patient

- Collection of the critical care quality measures data set: all providers are required to comply with and contribute to additional data sets as requested by the NW London Critical Care Network during 2014-15

- We expect provider to have all clinics and services available on Choose and Book as directly bookable service and to have good slot availability.

- We expect all providers paid for under an activity related payment system such as Payment by Results (PbR) to achieve the required Monitor tariff deflator

- For all providers paid under block contracts we expect them to apply the Monitor tariff deflator to all prices

- We will no longer commission local enhanced services from GP practices. Instead, a range of additional services will be commissioned under the standard NHS contract from practices or other providers. The full details are set out within the primary care section of these commissioning intentions.

Productivity intentions to apply to all providers:

- We will expect for all providers paid under an activity related payment system such as Payment by Results (PbR) to achieve the required Department of Health (DH) tariff deflator

- For all providers paid under block contracts we would expect them to deliver a productivity increase of 4% delivered by a combination of decreased price and increased activity for the same value

Services that we wish to commission consistently across all our providers:

We have chosen to work collaboratively with West London, Central London and Hounslow CCGs because we recognise that, while the way in which we implement service change will differ to reflect the differing needs of our populations, the strategic goals that we hold are shared. We are working jointly across a number of areas:

- Implementation of SaHF, and the Out of Hospital Strategies that it supports
- The development of Whole Systems working to deliver more integrated care across health and social services
- The implementation of a new service model for community nursing
- The development of a new service model for musculoskeletal services (MSK)
- Shared contracting intentions for our major NHS acute, community and mental health providers

The way in which we will be implementing these goals is set out in more detail in the next section of this document.

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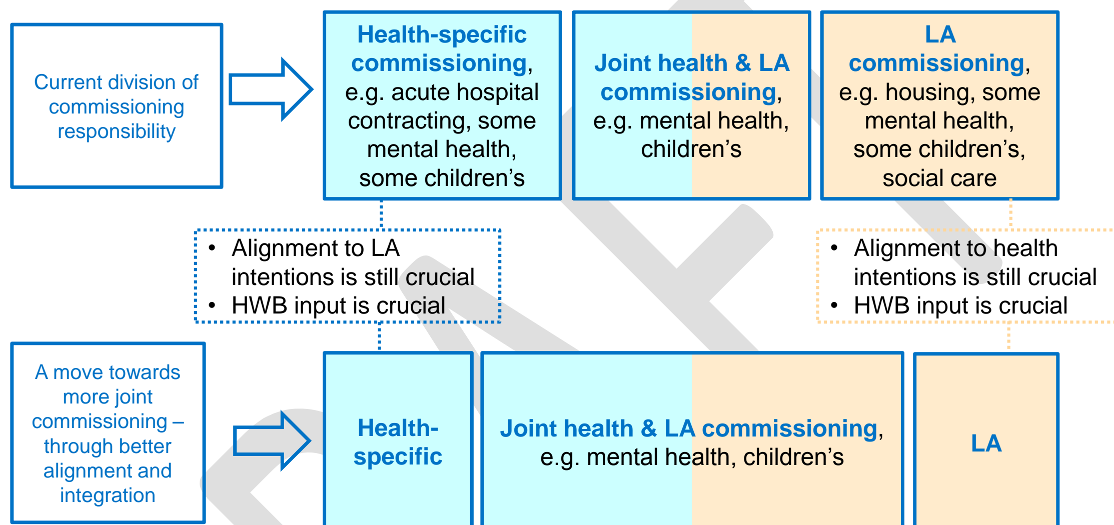
3. CCG-specific commissioning intentions

This section sets out our commissioning intentions for 2014/15. In developing our intentions, we have engaged widely across the CCG Governing Body and GP Membership and the CCG team. We have also involved patients, carers, service users and their representatives. More information about how we have engaged with people is given in the stakeholder engagement section of this document, along with some of our plans for continuing engagement.

In particular, we have developed our commissioning intentions in close collaboration with our LA colleagues. This section therefore also sets out those intentions that are joint intentions with the LA. It is our aspiration that over time, we move to a position where much more is joint – through both better alignment and through integration, as illustrated below.



In all areas, we recognise that our commissioning intentions for this year are consistent with the direction of travel we established in 2013/14. We have described the progress we have made as well as the areas where we want to strengthen our focus and/or address gaps. This year, we have structured our intentions so as to reflect the key themes of our work, including integration.

[DN – further content regarding the local hospitals work to follow here]

3.1. Integrated care including community services – joint intentions

As part of our journey towards whole systems integrated care CCGs and local authorities wish to see health and social care providers working together to deliver a coordinated holistic approach to all the needs of a person's health and wellbeing both physical and mental. During 14/15 we will explore how different community providers can work in a coordinated way to deliver outcomes for patients and how payment mechanisms and other systemic elements can support this.

To support this ambition the CCGs working with social care commissioners will specify what we consider to be core community provision that will be commissioned and procured as a single entity. This in turn will allow us to move to outcomes based commissioning. The

specification of the core service will build on the work to develop a single specification for the Community Independence Service.

Where we commission multiple services from the same community provider during 14/15 we will expect these providers to implement ways of working which deliver integration and coordination between their services as well as the rest of the health and wellbeing system.

Over time other community services will be commissioned and procured as packages of services reducing the number of service lines we commission and again allowing CCGs to move to outcome based commissioning. We will appoint providers best able deliver a package of services to meet patients' needs and the need to integrate and coordinate with other elements of the health and wellbeing systems will form part of all specifications.

Whilst there has been progress on the implementation of new models of delivery particularly with regard to community nursing and rehabilitation during 13/14, much of this change has yet to be embedded in organisations and we will expect community providers to ensure these changes are owned by clinical staff on the ground and become 'business as usual'. It is through these models we can deliver practical integrated care that benefits patients.

Across CWHHE we have begun the process of designing a new model of care for the parts of our populations we think would most benefit from an integrated approach from commissioners and providers. The co-design period is bringing together partners from across NWL including service users (lay partners), commissioners and providers from across health and social care to address some of the key questions for integration.

The recommendations that are developed through co-design will be taken forward, adapted and tailored for local implementation at borough level, with commissioning decisions made jointly by local authorities and CCG boards. It is anticipated that a number of 'early implementation' sites will launch in shadow form from April 2014 and these sites will receive investment support to implement their plans. The sites will demonstrate the impact of new models of provision while new funding arrangements remain in shadow form through 14-15. A programme of on-going evaluation and shared learning will run in parallel to these pilots. Based on this learning, we would then expect sites to go live in April 2015 with a real flow of integrated funds to providers. We will be asking for expressions of interest to be a Wave 1 site in December 2013.

A "toolkit" is being developed which will provide information on a) analysis of population needs, b) potential payment models, c) potential provision models. It is envisioned that this "toolkit" would be used to inform partners wishing to consider expressing their interest and also in then developing their plans further.

Applications will need both commissioners and providers to detail their integration plan. Health and social care commissioners, in partnership with NHS England where necessary, will need to explain:

- What population they feel would most benefit from integrated commissioning and provision
- The outcomes they want to achieve for this population

- The budgets that will be contributed and the whole care payment that will be made for each person requiring care
- How they will performance manage providers against the outcomes required
- The governance arrangements they will make between each other

In response to this specification, providers will need to provide an explanation of:

- The group of providers who will work together to deliver this care and the responsibilities of each member
- The care model that will be used to deliver better care
- What resources are currently used for the target population across all these providers
- How they can deploy these resources to deliver better models of care in order to achieve the outcomes required
- Governance and organisational arrangements for provider model
- How risk and savings will be distributed between providers
- Information requirements for outcomes, financial payments and people information is needed and how it will be provided
- How the proposed provider group will work within existing system

Based on the Whole Systems Integrated Care work, our commissioning intentions for integrated care will focus on the following client groups:

- Frail older people
- People with complex needs
- Long term conditions
- Vulnerable adults with physical and mental health care needs.

Progress to date

We believe we have made good progress with integrating services to support key client groups. Care planning is taking place to a greater extent than previously, and we know that we have kept some people out of hospital when this was not required. Our Community Independence Service (CIS) is a key development in keeping people out of hospital and closely linked to this we have also made progress in developing the 'virtual ward' model of care. Both of these initiatives also represent the development of better co-ordinated, joint health and social care teams and will be developed further in 2014/15.

Specific achievements from 2013/14 are:

- Our primary care Network Plan includes incentives to increase care planning, including transition planning/ enhanced discharge planning

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- GPs now have improved access to specialist opinions, including telephone support, for example in paediatrics, elderly medicine, mental health, and rapid access clinics for the elderly that GPs can refer into

- Multi-disciplinary groups (MDGs) have been established under the Integrated Care Pilot (ICP) and are currently being reviewed

- The Health and Social Care Co-ordinator (HSCC) 12 month pilot ended in June 2013 and formal evaluation has commenced

- The Community Independence Service (CIS) and the 'virtual ward' model have:

  - Streamlined referral pathways and developing a Single Point of Access (SPA) for all intermediate care services

  - Developed and implemented a new service specification for CIS service to bring about improvement in performance management, enhance quality (based on outcomes) and productivity

  - We have made progress on key deliverables on service integration with social care

  - Developed our virtual ward model so that it incorporates medical (GP) input and so that it draws on the learning from other integrated models including the ICP MDGs and the HSCCs

- Rehabilitation and interim beds (step-up and step-down):

  - Mapped current bedded provision for intermediate care against defined service types of provision and re-aligned rehab service pathways to maximise utilisation;

  - identified service gaps and capacity requirements

Intentions for 2014/15

Our specific intentions are to:

[DN – further content regarding the Tri-borough CIS to follow here]

- Develop a standard specification for the CIS across the Tri-borough - this will replace a range of existing services currently operating across the Tri-Borough. This will be a standardised service (standard opening hours, 7 days a week, single point of access) that is consistent across all 3 boroughs in Hammersmith & Fulham, Central London and West London. It will provide rapid response, re-ablement, in-reach and intermediate care, in order to enable people to be treated and supported in their own homes and to remain independent for as long as possible. It will be jointly commissioned by the 3 CCGs and the Tri-Borough LA Adult Social Care.

  The service may cover bedded services using step-up and step-down beds, rehab and social care transitional beds to shift the impact of care from acute services

It is proposed that there will be a phased roll out with alignment and co-location of teams occurring in 14/15 and full implementation of the service by 15/16

There are four principles which will underpin the new CIS:

Access:

- Improve access to the Community Independence Services for patients/service users and all health and social service professionals who need assistance to maintain care for people in the community
- Enable seamless and timely discharge from hospitals to home and interlinking between secondary, primary and community care systems
- To be a single point of contact accessing all available community care services, professionals and volunteers.

Resources:

- Develop a complete service that has the necessary resources to provide full multidisciplinary care in patient's own homes, integrated and interlinked with primary, secondary, social & voluntary care agencies - but not entirely dependent on them to deliver the care needed.

Workforce:

- Provide high quality, fully integrated, multi-professional, community-based service meeting people's urgent, intermediate and on-going health care needs
- Provide a platform where secondary care specialists (such as geriatricians) can integrate with and support community health and social care services
- To foster a "yes service" culture focused on the needs of the patient/service user.

Patient Pathway:

- Reduce service fragmentation and 'hand offs' in an individuals' care pathway
- Dissolve complicated referral pathways, difficult access criteria and single pathway approaches to care
- To operate as one service, from both a clinical and a patient/service user perspective.

- Improve access to the CIS through the use of the single GP IT system currently being rolled out across Hammersmith and Fulham – SystmOne. Specifically, we will work towards:
  - Ensuring interoperability with all our providers
  - Providing the CIS and the LA with access to SystmOne
  - Exploring the potential for patients to view their own records electronically

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- Work more closely with our colleagues in the acute hospital to promote the benefits of the CIS and build confidence in the service

- Explore development of the role of the CIS so that it supports people's wider care needs, such as social isolation and nutrition. A key part of this will be exploring the potential for links between the CIS and voluntary and community services (VCS)

- Fully establish the 'virtual ward' model. The model will be aligned to the CIS to improve productivity and will provide admission avoidance and rapid response services seven days a week, operating 8am to 8pm. We will also work towards commissioning an emergency night service for admission avoidance to be available for access from GPs,UCC andA&E

- Improve community services' capacity to prevent hospital admission and reduce Delay Transfers Of Care (DTOC)

- Work towards ensuring that care provided in people's homes is delivered by a single dedicated team of staff aligned to the patient's GP

- Improve patient transport where it is required to be co-ordinated between health and social care and provide it in the most accessible form for the patient

- Improve notification to primary care of patient attendances at hospital, linked to our virtual ward initiative

- Focus on developing care planning as follows:

    - Detailed care plans will be produced for all those in our target cohorts and will be co-designed with the patient, carer and the lead professional

    - The care plan will describe the actions the patient will take to look after themselves and the detail required regarding the pathway in the event of an exacerbation

    - Patients will have a known care/case navigator working for them and their GP

    - Care plans will be discussed and agreed with the multidisciplinary team where appropriate and all relevant providers will provide appropriate input

    - There will be electronic sharing of patient information (with patient consent)

    - Where patients require specialist diagnostic opinions, these will be delivered around the patient and co-ordinated without multiple trips to hospital

    - Full medication review will be included

    - We will work towards the use of a template approach (guidelines rather than detailed prescriptions) in order to support data capture, audit and quality control

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    - We will explore the potential for GPs to identify additional patients who are likely to benefit from care planning but who may not be indicated by their risk score. This could mean drawing patients from the 30-50 risk score cohort.

- Actively promote supported self-care/self-management and empower communities to manage their own health. We will work closely with our LA colleagues, including public health, on this. Specifically we will explore:
    - Prioritising ways of joining CCG and LA funding for more infrastructure to enable better self-management. This could mean:
        - Targeted health education and co-ordination efforts between health and social care to maximise outcomes e.g. marketing flu campaigns
        - Investing in third sector/preventative services that are targeted and evidence-based
        - Designing new programmes around people
        - Making more use of existing groups
    - The potential role for community champions in working with patients and the public
    - Working towards clear action plans that patients can follow which moves them to a self-care model
    - Increasing the uptake of patient education programmes
    - Increasing the use of electronic solutions and assistive technology, such as tele-health and telecare, and exploring this with the LA
    - The expansion of personal health budgets (PHBs)
    - Maximising the potential of the new facilities at White City as a setting for engaging with patients and service users on their management of their own health and wellbeing

We expect to measure our success in integrated care through:

- An increase in the numbers of people living independent lives for longer
- Reduced avoidable admissions
- Reduced lengths of stay
- Reduced use of institutional care such as nursing and residential homes
- People feeling more in control and aware of the choices they have.

We expect our whole system pioneer wave 1 sites to be providing related services and would wish to discuss commissioner and provider models that facilitate this; in particular we

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would wish to discuss moving to a shadow capitated funding approach for some or all of the pathways for these patient groups.

Our specific intentions for **community services** are to:

- Re-align community rehabilitation services into a single provision to maximise productivity and reduce service waiting times
- Reduce hospital delays and improve community rehabilitation capacity by increasing capacity for step up/down rehabiliation
- Ensure alignment of community nursing resource around GP networks including new ways of working where appropriate
- Demonstrate a 5% productivity increase in community nursing resource
- Separate all community services into those that are core to delivering integrated care to create a Target Operating Model, and those that are not core
- Reach a decision on preferred model for community service organisation in Tri-borough
- CWHHE will work with other CCGs as appropriate to procure and implement a new wheelchair service.
- Tissue viability services have been identified as a gap in community provision. We will review this gap and consider the feasibility of implementing a tissue viability service in the community. This area of work will also be picked up through the ICP nursing home innovation pilot
- Consider the potential to recruit a Homeless Peripatetic (Outreach) Nurse provide a service to hostels for the homeless.

3.2. Integration Fund – joint intentions

The Integrated Transformation Fund (ITF) will be a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between CCGs and LAs.

In *Integrated care and support: our shared commitment,* integration was defined by National Voices – from the perspective of the individual – as being able to, “plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me”. The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

The ITF does not come into full effect until 2015/16 although the government think it is essential that CCGs and LAs build momentum in 2014/15 using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and 2015/16.

Hammersmith and Fulham are required to develop a local plan by January 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan needs to also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

Plans for the use of the pooled monies will be developed jointly by CCGs and LAs and signed off by each of these parties and the local Health and Wellbeing Board.

Conditions of the full ITF

The ITF will be a pooled budget which will be deployed locally on social care and health provision, subject to the following national conditions which will need to be addressed in the plans:

- Plans to be jointly agreed
- Protection for social care services (not spending); as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health)
- Ensure a joint approach to assessments and care planning
- Ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached
- Agreement on the consequential impact of changes in the acute sector.

We need to have a two year plan for integration fund ready for January 2014. With our Health and Wellbeing Board we need to agree a timetable that delivers the following:

Step one (October/November 2013):

- Map out all the existing joint funding arrangements both covered within specific NHS social care transfers and other agreements with each Borough
- Agreed which services in this mapping are priorities
- Agreed the spend for 13/14
- Agreed how reablement funding is currently being used and assured that it is being used for reablement services
- Understand the impact of budget reductions on social care for 14/15 and 15/16

Step two (end of November 2013) we will have agreed our plans to:

- Achieve 7 day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Enable better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning
- Ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Risk sharing principles and contingency plans if targets are not met
- Agreement on the consequential impact of changes in the acute sector and how to mitigate
- Joint governance arrangements to oversee this

Step three (by end of 2013/early 2014) we will have:

- Produced a joint delivery plan with LBHF.

3.3. Urgent and emergency care – CCG intentions

Our aspiration is to take further action to reduce the volume of emergency activity in our hospitals during 14/15.

Our specific intentions are to:

- Implement the SaHF Urgent Care Centre (UCC) specification in all our UCCs wherever they are commissionedCo-design (between primary care and the acute provider) a service model for Ambulatory Emergency Care for the treatment of ambulatory conditions
- Require the use of a system in all UCCs and in Medical Admission Units (MAUs) that is interoperable with SystmOne (our single GP clinical system of choice)
- Commission the full roll out of the MCAP decision making software in MAUs in order to understand the potential for reducing emergency admissions in the future
- Continue with the cap of emergency admission activity in place at Chelsea and Westminster and Imperial and the consideration of this at West Middlesex and Ealing
- Commission services from trusts that meet the agreed London Quality Standards for Consultant delivered care seven days a week. This is a common commitment across CWHHE, and we will therefore agree a trajectory with each provider, recognising the starting point for each, aiming for full achievement by 17/18 as set out in the table below:

Speciality	Clinical Standard
A&E	16 hours / day
Emergency Surgery	12 hours / day
Emergency Medicine	12 hours / day
Critical Care	24 hours / day
Maternity	24 hours / day
Paediatrics	14 hours / day

- Re-procure during 14/15, the contract for practices opted out of GP Out of Hours (practices where the CCG contracts on behalf of the practice rather than the practice directly contracting with an out of hours provider). Integration with the 111 and UCC will be key
- Continue to monitor the current 111 contract with a focus on achieving the KPIs for service delivery including redirection. We will work with NHSE following their evaluation of the service enabling us to determine revised specification and procurement requirements
- Respond as required to the NHSE Urgent and Emergency Care Review led by NHSE Medical Director Professor Sir Bruce Keogh.

3.4. Primary Care – CCG intentions

The CCGs in North West London are working together to deliver transformed primary care. At the heart of this work is the intention to improve the quality of general practice and reduce the known variation. Working with NHS England the CCGs in CWHHE and BHH will continue the work started in 2013/2014 to determine what good quality general practice is and what models of care could support this. CCGs in CWHHE will undertake a piece of work to understand the variation in funding across general practice and will then work with NHS England to find a mechanism that enables us to move a fairer funding system during 2014/2015 and beyond.

Progress to Date:

Our key progress to date includes:

- All Hammersmith and Fulham GP practices are committed to working together as part of five GP networks. The work of these networks is supported in 2013/14 by a robust network planning process which seeks to ensure that:
    - All patients have access to high quality services delivered by the right person, at the right time and in the right place
    - Care is delivered closer patients' homes and that care is delivered in the community wherever possible

- Primary care prescribing is high quality, cost effective and appropriately reviewed to meet patient need.

- As of October 2013, 20 GP practices in Hammersmith and Fulham (two thirds of practices) are using SystmOne. This represents nearly 70% of registered patient records. This is a significant milestone and we are looking to hit 100% by February 2014.

Intentions for 2014/15

Recommissioning of Local Enhanced Services

From April 2014 CCGs will no longer have the ability to commission local enhanced services from primary care providers; instead CCGs will be required to commission any out of hospital services required using an appropriate and proportionate procurement process and the NHS Standard Contract as the contracting mechanism.

As a consequence CCGs are reviewing all the local enhanced services that have been commissioned and are concluding which services that they wish to retain.

The arrangements have not yet been finalised. However, we expect to apply the following principles in our decision making:

- High quality, financially sustainable primary care is vital to the strategic direction of all the CCGs, and so no financial savings will be sought through the review. Current levels of expenditure across the 5 CCGs will be at least maintained, and investment will be made in some areas

- All services are being considered from the perspective of the patient. We will therefore be seeking to integrate care and provide it as holistically and as close to home as possible where this is in the best interest of the patient and where value for money can be demonstrated. We will be ensuring that where appropriate, the integration of services for the patient will outweigh the fragmentation of service provision through procurement

- Services that are currently commissioned through LES will be either decommissioned; recommissioned in their current form using a standard NHS contract or recommissioned to a different service specification using a standard NHS contract

- The CCGs have developed a Commissioning Framework to support decision making for the re-commissioning of Local Enhanced Services based on the draft guidance issued by Monitor. This will be subject to review as and when the Monitor guidance is finalised. The framework is included at Appendix 3

- Future models of primary care are currently being developed. All CCGs are currently exploring ways of working across networks of practices to best provide care for their patients, and this is likely to lead to many services that are currently provided through LES being provided in future by a network of practices providing services to their own patients or on behalf of other practices within the network.. We see this model as key to the delivery of whole systems integrated care and we will therefore identify a

number of services where primary care is most capable and 'best able' to deliver those services

- In line with this, where practices are commissioned to provide services at scale to patients from other practices within or across networks, the practice will be required to meet minimum quality standards before they will be able to do so

- All CCGs will be working towards commissioning a common bundle of services that will be provided by individual practices or by groups of practices across localities or networks. CCG will commission services using a service specification and pricing structure agreed across the five CCGs. CCGs will be working together to fund the required investment in primary care

- Transitional funding arrangements will be considered for providers whose income is materially affected by the changes from LES, to enable them to manage the change and continue to provide safe services to patients

- We expect to compete a small number of services that are currently commissioned using LES contracting mechanism. However we expect the list to be limited.

The CCGs will look to commission services from all providers of general medical services but will work with NHS England to ensure that there is no duplication of service or payment in relation to PMS or APMS providers who deliver services above and beyond the requirements of the general medical services contract.

The CCGs will aim to move to this commissioning arrangement as early as possible in 2014/2015. In order to ensure continuity of service provision the CCGs will transfer services currently commissioned as enhanced services on to standard NHS Contracts with effect from 1.4.14.

The above intentions and table below are subject to further assessment and testing by CCGs and the CCGs may amend these as further work is undertaken.

CCGs will issue decommissioning notices to providers for those enhanced services that they do not wish to commission in 2014/2015. The recommendation from the enhanced service review is that the Elgin Close Local Enhanced Service should be decommissioned.

Appendix 2 sets out the framework that we are using to make decisions regarding the future provision of services currently commissioned via LES.

1.0 CLINICAL	EXAMPLE SERVICES	RATIONALE	Initial Assessment of Commissioning Route
1.1 Enhancement of existing core service provided by General Practices	Care planning / care management Enhanced access to routine primary care Co-ordinate my Care Post operative wound care	In line with whole systems strategy that puts GPs at the centre of coordinating patients' care Requires clarity of accountability (which remains with GP Practice) or are list based services	Signal in commissioning intentions that we expect to commission these services from individual practices and will look for 100% coverage from General Practice. Individual Practices

	Ambulatory blood pressure monitoring	Service will need to be integrated with existing care / provide continuity along a pathway	may subcontract to other General Practices to enable CCG to get to deliver equity of access.
1.2 Additional service – provider will need to demonstrate capability. Continuity of care and integration of service provision are seen as critical	7 day access to routine primary care Mental health – primary care plus services Enhanced management of patients with long term conditions: • Anti-coagulation services for stable patients • Insulin initiation • Methotrexate prescribing • Services for homeless patients Violent patients	Service will need to be integrated with existing care / provide continuity along a pathway Requires clarity of accountability (which remains with GP Practice) To provide best quality the service may need to make best use of scarce skills to serve a network of GP practices Or Service could give patients choice of provider Service providers will need to utilise SystmOne, the shared patient record	Signal in commissioning intentions that CCGs expect to commission services across networks. CCGs will look to award to "lead" practices who can deliver services on behalf of patients within their network. To get coverage across networks sub-contracting across networks would be allowed
1.3 Additional service – multiple providers possible but location of service provision seen as important to ensure continuity of patient care	**Service best provided from within practice buildings unless VFM or other considerations make this impossible, at which point competition of providers may be sought.** Phlebotomy Near patient testing Counselling	Service will need to be integrated with existing care / provide continuity along a pathway Wider holistic benefits can be gained by providing services in a setting where the patient is also receiving other aspects of care at the same time Requirement for multiple locations reduces opportunity for VFM being achieved through a procurement and increases the administration costs associated with managing contracts	Signal in commissioning intentions that CCGs expect to commission services from individual practices. Where practices decline to provide service, procurement or sub-contracting across networks would be sought to ensure services are provided for all patients
1.4 Additional service – provider will need to demonstrate enhanced skills requiring further training / accreditation	**Any Capable Provider** Minor surgery Joint injections Psychological therapy in primary care (IAPT) Homeless nurse outreach	Already other providers in the market and generally not provided by general practice itself	Signal in commissioning intentions that the Contracts will be completed during 2014 but in the short term contracts may be migrated over to NHS Contracts as a holding position

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- Review access to general practice services and working with practices understand the impacts of the moves toward 7 day a week working, consider how this is best achieved and consider how this is commissioned.
- Continue to support the development of GP Networks specifically looking at the organisational development needs of networks and providing support to address these needs.
- Working with NHSE, the Public Health team in the LA and community groups understand the problems associated with low uptake across screening programmes and work to find solutions to address these
- Achieve a reduction in prescribing costs
- Continue to build our relationship with NHSE to improve the quality of general practice
- Work towards delivering the core GP standards agreed as part of the NWL primary care transformation programme aiming to reduce the know variation in services delivered and outcomes across general practice in Hammersmith & Fulham

3.5. Commissioning of Nursing and Residential care – joint intentions

Progress to date

Our achievements include:

- Maximising use of contracted beds in nursing homes across Tri-borough (i.e. implementing a cross charging mechanism to allow clients from all 3 CCGs to use local contract beds)
- We have secured additional capacity to deliver Department of Health requirements for the retrospective appeals process (IRP)
- We have begun work to increase local capacity for clients with very complex needs (increasing skill mix and competency in Farm Lane and St Vincent's) to reduce need to place clients out of borough. This work will continue.

Intentions for 2014/15

[DN – further content regarding the Tri-borough nursing homes work to follow here]

We are committed to ensuring that members of our community who live in residential and nursing homes have the highest quality of care and support. This will become more and more important as demographic changes mean greater demand for these services.

We have a shared ambition for our nursing and residential provision:

- More people supported to live independently for longer and delayed in going into institutionalised care

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- When institutional care is required, more appropriate placements in high quality care settings which exceed Care Quality Commission standards

- More people living longer with reduced isolation, falls and unplanned hospital admissions

- More clients and their families involved in and happy with the placements made.

At the moment our nursing and residential provision is mixed. Whilst there is evidence of pockets of good practice across all three boroughs, there are differing team structures, resources and approaches. There is variation in demand placed on other services, differences in levels of satisfaction and differences in outcomes.

In order to reduce variation, the CCGs and Local Authorities are taking the following approach:

- Consistency of contracting:
    - One single, uniform approach to care contracts including large block contracts and the large volume of spot contracts for out of area care placements
    - Clear funding arrangements in place supported by the Section 75 agreement which includes staff funding as well as revenue budgets.

- Robust single approach to monitoring quality, outcomes and use of resources:
    - One shared health and social care outcomes framework for care homes
    - Improved identification and resolution of contractual issues
    - A single and effective approach to responding to safeguarding concerns.

- Comprehensive approach to safeguarding:
    - Improved safeguarding - the way alerts and episodes in quality of care are managed in a co-ordinated way by all
    - Shared responsibility for use of nursing home and residential home capacity
    - Joint decisions on placements including a comprehensive health and social care assessment.

We will put in place a single Care Home Quality Dashboard that tracks quality of delivery from both a setting and placement perspective.

We also need to monitor the impact of these changes within our own organisations and will be looking at a number of KPIs including:

- Reduction in contract expenditure - benchmarked against other London Boroughs

- Reduction in spot placements

- Increase in client and resident satisfaction

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- Increase the number of block placements available and the number of providers who provide block placements.

We also have specific intentions to:

- Have in place robust medical cover arrangements for all nursing homes and care homes that are commissioned to provide services for us. We will consider the current models and look to roll out the most approriateEnsure arrangements for safeguarding adults for both health and the LA are aligned and that joint approaches for the management of concerns, escalation and action are embedded in joint, coordinated multiagency working

- Ensure our GPs can access up to date information regarding care pathways and the specific services currently available, e.g. step up and step down care, nursing homes, residential care

- Explore the potential for more care to be delivered in clients' homes, for medical cover in supported housing, for the use of assistive technology, and for more integrated decision making and more involvement of GPs in reviews. We will also seek to develop better links between health, social care and housing

- Explore how we can increase flexibility in how residential placements are funded to allow other needs to be met, e.g. cultural needs

- Support better IT connections for nursing homes

- Consider developing a care home strategy supported by a nursing home strategy group

- Continuing healthcare – we intend to:

    - In line with national requirements, implement Personal Health Budgets for people eligible for continuing health care in 2014-15 and prepare for wider implementation for people with long term conditions who do not meet the threshold for continuing health care from April 2015

    - Achieve equity and consistency in provision across the Tri-borough. We will review the need for additional capacity and invest as appropriate

    - Agree and implement commissioning and quality assurance framework for care homes.

3.6. Planned care – CCG intentions

Our aspiration is to increase the proportion of care that is planned but also simplify the existing pathways with more of the diagnostics and decision making carried out in community settings.

CCGs within CWHHE will be reviewing and developing planned care pathways and community provision aligned to their own strategic priorities and population needs. The CCGs within CWHHE will work together to understand the models that are developed and will look to evaluate these locally and implement best practice wherever possible.

Progress to date

In 2013/14, the CCG has commissioned a range of community-based services that provide patients and referring doctors with alternatives to traditional hospital-based care for the following pathways:

- Gynaecology
- Dermatology
- Respiratory
- MSK
- Diabetes.

Intentions for 2014/15

Over the last few months, CWHHE CCGs have been working closely with Imperial to review improvements and transform planned care. This has been supported by the NHS IQ development programme. Outputs from the work that are emerging can be translated across all acute providers for CWHHE. Expected outcomes for accessing specialist advice are:

- Maximizing the benefit of a Single Clinical System by increasing availability in out-patient, pre-assessment and rapid access clinic settings in secondary care
- Realising a change in behaviour so that both primary and secondary care are working together to make savings for the health economy, make sure patients are treated in primary or community care when they can be. This could include
    - Email / telephone consultation between the GP and consultant
    - Consultant triage of referrals to ensure they get to the appropriate sub-specialist opinion
    - Consultants undertaking clinics in primary care (e.g. proposed Community Paediatric hub model)
    - Consultants inputting their decisions directly into GP IT systems
- Reduction in patients having to "pin-ball" around the system – when multiple and sequential appointments are required for referred condition (including diagnostics/ sub-speciality transfers)
- Increased and consistent availability of one-stop and or joint speciality clinic availability across a range of specialities
- Increased communication and access between clinicians to help manage individual patient care management plans
- Increased number of patients with joint care management plans and case management where appropriate

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- System working with agreed and shared pathways / guidelines which clearly define the diagnostic requirements prior to first appointment and subject to regular clinical audit to review effectiveness or need for change to agreed pathways / specialities

- Effective mechanisms across the system for the exchange of knowledge of services and pathways across community/secondary care to enable patients to be on correct pathway

- Alternatives to face-to-face consultations, increasing availability of telephone consultations when clinically appropriate

- Quantifying the expected activity defined as Internally generated – with KPIs and CQUINs aligned to support system transformation where appropriate

- Using these outcomes to support the development of networks/ hubs managing patient care

- Improving appointment booking processes - feedback from both patients and staff working within the system identified the need to:

- Improved availability of routine and urgent appointments on choose and book

- Review/ clinical triage of referrals within the trust prior to first appointment to /from subspecialties as required

- Receive and act upon communication from patients regarding appointment suitability / attendance and as a consequence review of DNA processes

- Consider use of alternative mechanisms for handling and managing (nearly) all referrals

The 14/15 actions will be for providers, the CSU and CCGs to deliver transformation by:

- Inviting providers to propose how they will assist with transformation of efficiencies within the system and suggest contract payment and incentive mechanisms for this

- All acute trust divisions, to sub-specialty level, to review the activity data identifying Internal pathways that lead to internally generated activity with a view to transforming pathways to joint clinics / one stop clinics / diagnostic results available at first appointment and share with the CCGs. This to be supported by regular clinical audit for impact.

- One-stop shop clinics – review of proportion of patients able to attend a one stop shop clinics, increasing availability and throughput – this should include vascular, urology, gynaecology, (and uro-gynae), gastroenterology, cardiology

- Pre- assessment clinic pathways - review diagnostic bundle availability at speciality level

- Review process for patients who do not meet surgical pre-assessment screening thresholds – develop protocol specifying actions required that are jointly agreed with the patient's GP and ensuring access to GP clinical records (via SystmOne)

- Develop pathways with direct access to specialist for urgent / emergency review to avoid A&E (working towards seven days a week) – with initial consideration focused on gynaecology / cardiovascular

- Develop and implement referral guidelines / pathways

- Ensure diagnostics availability consistent availability 7/7 and with increased access (towards 24/7) for acute wards

- For agreed conditions / diagnoses consider mechanisms that enable patient moving straight to list from diagnostic

- Within the contract discussions for 14/15 the following will be discussed and agreed

  - Incentivise providers to redirect to appropriate community service and include mechanism whereby payment will not be made if this has not been done

  - Introduce a single charge for patients referred from A&E to other emergency OP based services e.g. early pregnancy unit

  - Restrict referrals to other specialties made following an inpatient discharge to having agreement from GP

  - Agree the specialities where all internal referrals (e.g. GUM) must to be returned to their GP/ Referral service; expectation is that some specialities will have zero internally generated referrals (IGR)

  - To quantify current IGR activity and targets for the 14/15 – 15/16 contracts

  - Agree how CQUINS and KPIs can be used to enable the system and avoid any unintended consequences / disincentives

  - Where appropriate agree local tariffs – for example for one stop shops and telephone consultations

- The CCG will continue to commission Planned Procedures with a Threshold (PPwT) and Individual Funding Requests in alignment with NWL on both these areas. The guidance has three main sections of commissioning intent:

  - Planned changes to existing PPwT Policies

  - New Policy Development

  - Changes to PPwT/IFR Governance Process.

Other specific intentions for planned care are to:

- Review all care pathways with a view to understanding what conditions primary care physicians can manage and what consultants can manage. We will explore the potential to up-skill primary care to deliver planned care more effectively in this context. We will work with Primary Care Clinicains to prioritise the order that this is done in,

- Consider the business case for enhanced primary care services across several key pathways. This could include:
  - Diabetes: including more easily accessible and simpler structured education programmes, the potential for insulin initiation and enhanced annual checks, the potential for accreditation/minimum competency requirements for providing services beyond the basic level, development of a pre-diabetes register, and specialist services
  - MSK: In previous years, the four / five CCGs in CWHHE (+Ealing) have independently commissioned their community MSK provision resulting in a range of different services for orthopaedics, rheumatology and chronic pain management. There are many examples of good practice being implemented including, for example, simplifying the patient journey and delivering care in community settings closer to home to improve outcomes. A common QIPP goal of all the CCGs was to reduce referrals into acute orthopaedic services. Unfortunately the impact from the existing community based MSK services to date has been lower than expected.

    Commissioning of the MSK service(s) in 2014/15 will seek to reduce the number of inappropriate referrals to acute orthopaedic services. This will include making practical improvements to the existing services (Central booking service, GP direct access physiotherapy, CATs, Pain Management service) to achieve the reduction in referrals. These improvements would be consistent with best practice implemented locally. There will be development of commonly agreed referral criteria, with benchmarked data specific to each CCG, for diagnostics and referral agreed by the GPs, consultants and radiologists across CWHHE and Ealing in the last part of 2013/2014 and all providers will be expected to work to these in 2014/2015.

    During the quarter 4 of 2013/2014 work will be on-going to determine an appropriate service model for MSK services. It is likely that the CCGs will look to tender for this service during 2014/2015 though this will be subject to a decision making process once the final service model is agreed.
  - Cardiology: management of heart failure has been identified as a system gap by many GPs. We will explore the potential for a community service to manage heart failure outside the hospital and to reduce admissions and outpatient referrals
  - End of Life Care (EOLC): including building on Co-ordinate My Care implementation, the implementation of any recommendations from the review of the Liverpool Care Pathway, and developing a more holistic approach to EOLC
  - Chronic kidney disease (CKD): we will continue to work will colleagues across NWL to review and improve the care pathway between primary and secondary care

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- Support implementation of the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London. Initially focused on pathology but extending to other diagnostic services. Ensuring that ordering tests and receiving results for primary care are almost exclusively done electronically. As well as ensuring that access to a comprehensive chronological patient diagnostic record is enabled and actively in use in different settings of care

- Agree with Imperial a diagnostic formulary for primary care

3.7. Cancer – CCG intentions

Our priorities for cancer commissioning intentions cover these main areas:

- Early detection pathways and what we need to commission as a result

- Increased endoscopy investment to reflect bowel cancer screening extension

- Survivorship treatment planning

- Urology patients requiring only monitoring of PSA levels to be discharged from hospital with follow-up in primary care.

The implementation of early detection best practice commissioning pathways

Early detection pathways have been developed for lung, colorectal and ovarian cancer and these will be included, with the living with and beyond cancer pathway elements, in the revised best practice commissioning pathways. These will be included as service specifications within the 2014/15 contracts. The main recommendations are:

- Ovarian pathway:
    - Undertake both CA125 and trans-vaginal ultrasound concurrently
    - Ensure GPs consider referral along colorectal pathway

- Colorectal pathway:
    - Commission direct access to one stop diagnostic service in secondary care
    - Reduce the threshold age for referring new onset colorectal symptoms from 60 years of age in 2013-14 to 55 years of age in 2014-15 and 45 years of age in 2015

- Lung pathway:
    - All primary & secondary care staff trained in giving very brief advice in smoking cessation
    - Develop excellent links with local stop smoking services
    - Ensure safety-netting processes in place to ensure patients, where appropriate, are recalled for chest X-ray.

Increased endoscopy investment to reflect bowel cancer screening extension

An evidence-based strategy is currently being developed to provide the case for each CCG, highlighting the difference between the level of services currently being commissioned and what is proposed for 2014/15 and beyond. The main recommendations are:

- Commission only from JAG accredited provider whether NHS or private
- Commission additional endoscopies as per the early detection best practice commissioning pathway for colorectal cancer
- Ensure surveillance approach for symptomatic patients means all patients are recalled appropriately with no patient at risk of falling through the gap

3.8. Mental Health – joint intentions

Progress to date

Our achievements include:

- We have dworked to establish multi-disciplinary enhanced primary care services
- We wanted to support more effective communication between primary and secondary care clinicians in 2013/14, and have now agreed communication protocols for use involving GPs and secondary care clinicians
- We invested in additional capacity and have successfully met the national IAPT targets
- We wanted to conclude the first line integration of health and social care dementia services and evaluate possibilities for further integration. The drafting of the final service model is in progress and agreements between organisations are being sought
- The CantabMobile dementia screening pilot has been implemented across five GP practices and a mid-way evaluation paper has been drafted for circulation. The pilot has been extended to gather more usage data
- The work to remodel and retender the dementia outreach service (joint funded with LA grant) and dementia day resources is in progress with the LA commissioner

Intentions for 2014/15

Our specific intentions are to:

- Protect mental well-being – we will work with public health and other departments such as regeneration (particularly in relation to employer engagement) and environment to develop an action-plan for interventions which promote mental well-being and resilience and which reduce stigma, including supporting national campaigns such as Time to Change

- Improve access – full roll out of the operational standards, principles and procedures agreed across NWL (see Mental Health Access Policy for NWL, October 2013), including a single point of access/phone number per CCG area

- Develop Urgent Assessment & Care (Phase 1) – concrete progress through redesign by secondary providers towards (a) extension of daytime hours to better match those in primary care (8 am – 8pm); (b) a single point of access 24/7/365 for all GP advice and referrals and (c) increased home visiting 24/7/365 to resolve new crises in people's homes, reducing the need for patients to travel to A&E departments after daytime crisis/urgent assessment services close

- Develop Urgent Assessment and care (Phase 2). The NWL Mental Health Programme Board will, as a London SCN Pathfinder, lead a systematic, multi-agency review of how urgent mental health assessment and care is commissioned, organised and delivered against national best practice and emerging NHS England expectations. Scoping work to take place October – March 2014, with actions identified during Q1 2014/15 and implementation taking place to year end

- Develop psychiatric liaison services (LPS) – In line with the NWL-wide review, a common specification and contracting of services in particular at the Chelsea & Westminster (with CLCCG) and St Mary's Hospital (with H&FCCG) to ensure equity of access, improved performance, consistent standards assurance reporting and a 'fair shares' approach that recognises usage by CCG and the financial cost saving benefits to acute hospitals through inappropriate emergency admission avoidance, medication review and length of stay minimisation for mental health patients

- Improve the quality and evidence base in Mental Health – implementing Payment by Results for mental health. In line with NHSE and DH timetable, CCGs and Trusts will need to develop a clear work programme to review existing practice and standards against those published NICE guidelines associated with Care Clusters and PbR. We will also work with the Mental Health Trusts to ensure continuous improvement in compliance with statutory duties and the Mental Health Code of Practice. The review will span primary and secondary care with recommendations for 2015/16

- Develop Whole Systems transformational change to the shape, scope and setting of community mental health service to models where they are increasingly delivered within multi-disciplinary services based in primary and community settings. This step change will be at the core of work to ensure parity of esteem between physical and mental health, securing increased delivery of these services side by side, in the least restrictive settings and at the point of demand rather than existing service location. Within this we will seek to ensure that those with mental health problems have improved physical healthcare, the mental health of those with long term conditions is proactively managed and also the promotion of self-management

- Within this, we will implement year 2 of the shifting settings of care project to manage patients in primary care community settings rather than secondary care. This programme is being implemented with service users and their carers to ensure that service change is co-produced and embedded to facilitate professional good practice and deliver a fundamentally different experience for those accessing care

- Review rehabilitation service provision and develop a forward commissioning strategy across the sector, with further re-patterning of Out of Area placements into local facilities

- Review, with the LA, mental healthsupported housing and floating support schemes to ensure good pathways that support recovery. We will review the needs of people in homelessness accommodation and single homeless supported housing to ensure their mental health needs are met effectively, especially in view of the impact of the Housing Benefit changes

- Implement clear pathways for patients in secondary care and primary care to access paid employment, training, education, volunteering, positive social networks and other meaningful activity and ensure we have information systems in place to make sure everyone understands how they access this provision. We will consider supporting the development of social enterprises where this is a feasible business model

- Implement recommendations from the tri-borough mental health service user involvement review to ensure that we have systems in place for meaningful co-production and involvement in the new commissioning landscape and to reflect shifting settings of care

- Develop a new strategy for 2014-19, as per the operating framework requirements for dementia care. In particular, we intend to:

    - Improve the dementia diagnosis rate assessment and diagnosis provision and MRIs and we will review current levels of investment in these

    - Review IT resources and in training/support programmes

- Continue to explore with the LA public health function the potential for dementia prevention, including a JSNA for Tri-borough Joint Dementia Strategy

- Improve physical rehabilitation for people with functional or organic mental health needs to reduce length of stay and prevent avoidable readmissions to acute hospitals

- IAPT – we will make targeted improvements to ensure we deliver the 15% national ‘treatment penetration’ ambition and increased recovery rates. In addition, the CCG will review IAPT services to ensure that they are equitable for all groups, with a particular focus on older people, young people, people with long-term conditions, carers and BME communities. There will be a community contract in place to support the assessment of mental health needs and the appropriate referral for treatment

- Measuring Outcomes, Testing Satisfaction, Assuring Quality, Delivering Value. Development and delivery of a rationalised set of required monthly dashboard indicators, including national requirements, outcomes, productivity and performance metrics, to support NWL-wide benchmarking. To be in place from April 2013 latest, for May reporting, and monthly thereafter

- Work with the Local Authority to improve recording on Framework-I and to develop meaningful joint indicators which evidence the effectiveness of the mental health

system in delivering good outcomes for people with mental health needs and their carers and families. Within this we will include improved monitoring of patient-reported experience and recovery and carer experience

- Implement recommendations from the review of dual diagnosis services taking place in RBKC and develop a business case for the best management of dual diagnosis services, which will include agreed pathways for people with both a mental health and substance misuse condition. In Hammersmith and Fulhamwe will take learning from this review to inform service improvements locally

- Commence a programme of reviewing and developing protocols for working with people with mental health and other needs including people with learning disabilities and people in the criminal justice system and we will also review develop transitions protocols from CAMHs to adults and from adults into older people's services

- Work with the Local Authorities to deliver more personalised and flexible services that respond to individual needs and preferences

- Commence a review of the following areas of service provision to determine if there are gaps in services or the need for service improvement:

    - Services for hoarders
    - Parental mental health services
    - Peri-natal mental health services
    - Tier 4 psychology.

- Work with public health to ensure that the health and well-being priority around substance misuse is addressed appropriately

- Patients and the public have also told us that we should also focus on men's mental health and mental health advocacy. The CCG will consider opportunities for this during 2014/15.

3.9. Learning Disabilities – joint intentions

Our intentions are to:

- Ensure that the learning from the Winterbourne View Inquiry continues to be implemented which takes into consideration any gaps identified in the 2013/14 Learning Disabilities Safeguarding Self–Assessment Assurance Framework (SAAF)

- Work closely with the LA to review the quality and capacity of the community based support for learning disabled people

- Increase the percentage of learning disabilities patients who have had a GP annual review; this is one of the CCG's Equality Objectives 2013-16 and there is an action plan in place to achieve this

- Continue to work with primary and secondary care to improve both access and experience of mainstream health services for people with learning disabilities
- Work with providers so that in-patient services take full account of the needs of the individual to ensure a timely and appropriate return to the community through the use of transitional arrangements
- Work in collaboration with other CCGs across NWL to improve the local services and response to people experiencing a mental health crisis.

3.10. Autism – joint intentions

Our specific intentions are:

- The Autism Self-Assessment Framework identifies the need to consider the needs of older people with Autism. This will include diagnostic and assessment needs as well as specific services. This will be considered in line with the Tri-Borough Autism strategy
- The Autism Self-Assessment and Learning Disability Joint Strategic Needs Assessment identify the need to offer post-diagnostic support. In addition, the Tri-Borough Autism Strategy and CWHHE equalities plan identifies the need for early intervention services to prevent people on the Autistic spectrum utilising the mental health pathway where this can be avoided by the use of community based services. There is an intention to commission an intervention project to support this.

3.11. Children's services – joint intentions

Progress to date

Our achievements include:

- Integrating speech and language therapy (SALT) commissioning
- Community midwifery is in the process of moving to Children's Centres or GP practices across the Borough
- Diabetes support at home
- 'Itchy Sneezy Wheezy' model – ground breaking approach for long term conditions with 'out of hospital' lessons
- Through our dialogue with all providers we have improved maternity services including an improved community offer and there are high satisfaction rates from mothers
- Consultant obstetrician cover at Chelsea and Westminster has increased although it needs to increase further next year.

Intentions for 2014/15

Our specific intentions are to:

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[DN – further content regarding connecting for care work to follow here]

- We will improve the way in which we support children through implementing Connecting Care for Children's Health (CC4C). Building on the evolving locality based GP network structures CC4C will increase community capacity to support children while also working with families and children to build their own resources and capabilities. Addressing both ois central to achieving reductions in A&E attendances, outpatient attendances and acute-based procedures.

  All of our relevant providers will build on network activity already underway in CCGs, and relationships already established. Providers will develop value from the wealth of expertise already present within the local health economies. Rather than superimposing an additional or separate system, CC4C is intended to co-ordinate activity to:

  - Bring current professional expertise and existing resources together to more effectively deliver care
  - Build collegial relationships which facilitate the exchange of knowledge and skills
  - Increase timely access to primary care for patients
  - Enhance patient capacity to understand the local health and care system
  - Build parent confidence in the local health and are system
  - Improve peer to peer support, especially among young people with long-term conditions

  At the heart of Connecting Care for Children's Health are three elements:

  1. Paediatric outreach – multi-professional case-based learning sets and joint outreach clinics to position the GP Surgery as the central point for integrated child health care
  2. Patient public capacity – recruiting, training and supporting a network of practice champions to lead patient engagement and co-production, enabling peer support and self-management, and ensuring that GPs, acute clinicians, and patients work together as standard
  3. Open access – supporting telephone and email consultation between GPs and paediatricians, and same day access for patients and GPs.

  We will increase capacity in primary care and will achieve this through localities, with networks of practices covering a minimum of 20,000 patients (approx. 4000 children). When fully operational the CC4C network will include primary care staff (eg practice nurses), acute partners, specialists and other local partners (eg early years settings, early intervention, social care, schools, CAMHS etc).

  The precise members of a local CC4C will be flexible to enable adaptation of the core model to reflect H&F requirements.

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The model will serve the full spectrum of children, from the healthy child who requires good health promotion and advice, to the acutely mild to moderately unwell child.

Connecting Care for Children's Health represents a new model of care and requires new relationships. We therefore expect the provider to invest up front in developing the model with the local delivery partners and work to an agreed roll out programme. We will ensure adequate resource is given to driving the change and to support localities in the development of their CC4C provision.

The Child Health General Practice Hub framework will deliver:

- Better outcomes for children, through coordinated care management; joint decision making; and treatment of children and young people within an outreach setting.
- Development of the workforce, underpinned by enhanced paediatric skills, confidence and competence across the system, focused on primary care.
- Better quality of care for children, closer to home, in a known and accessible environment, engendering confidence in the use of primary care
- Self care networks and community support for families, especially those with long term conditions.
- Reduced use of unscheduled care, inpatient admissions and paediatric outpatient referrals via improved out of hospital care.
- Effective and apposite access to specialist paediatric skills in the context of primary care.
- Financial savings across the system.

We will measure impact against all of these listed above, as well as agreeing activity measures that need to sit underneath this.

We expect that each locality may have locally defined measures. However, in all areas we expect that there are measures against our agreed outcomes:

- Reduction in outpatient services of 20%;
- Reducing A&E attendances of 10%; and
- Achieving a fall in admissions of 2%.

- Work closely with social care and education partners in our Local Authorities to develop robust plans for delivering the new Children and Families Legislation (statute September 2014). This has particular emphasis on joining up services for children with special educational needs and disabilities (SEND) and requires LAs and CCGs to develop; a local SEND service offer, a joined up education, health and care (EHC) assessment and planning process and personal budgets for EHC provision. This will include follow on work from the child development review (12/13) and include

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occupational therapy service developments and pathways for conditions (such as ASD - see links below to CAMHS). We will consider tendering for a single OT service

- Implement 'joint commissioning' for Speech and Language Therapy led by health establishing lead commissioning developments led by health key performance indicators and a new common service specification we will with jointly agreed in commissioning and delivery strengthen user involvement and/or co-production

- Develop a personal health budget offer for children eligible for continuing care, available from April 2014. This will put patients (children and parents) at the heart of decision making and help us to offer more child led, flexible and innovative solutions that improve outcomes for children with the most complex health needs and disabilities

- Health Visiting: work with the lead commissioner of health visiting (NHS England) to ensure that local arrangements and service developments are addressed at a local level and any performance issues raised with NHS England. This will be underpinned by a Memorandum of Understanding with NHS England, setting out the joint arrangement. We will be supported in this work by the local Public Health team. We will work with Health Visitor service to ensure effective joint working with General Practice through the connected care for children model, supported by the use of a SystmOne (our single GP clinical system of choice)

- Improve outcomes through Child and Adolescent Mental Health Services (CAMHS), including completing a review of Tier 2 and Targeted CAMHS. Alongside this there will be a review of both CAMHs On Call and CAMHS psychiatric liaison and the implication of this on tier 3: - There also needs to be work done around firming up pathways for children with ADHD and ASD to ensure good shared care

- Integrate Re-think Patient Experience work into service re-design plans. Implement improved performance framework and service specification with West London Mental Health Trust

- Deliver with the Tri-borough and Public Health colleagues a clear business case for child and adolescent drug and alcohol services across West London CCG, Hammersmith and Fulham CCG and Central London CCG

- Immunisations: we will work with NHS England and the local public health team to ensure that immunisation programmes and Family Nurse Partnership services work to their best effectiveness

- There will be an increasing emphasis on delivering midwifery in the community except for those with complex needs, linking it with GP shared cases more effectively. There will be a rigorous focus on performance reporting of the quality of user experience as well as caesarean sections, never events and consultant cover. We will contribute to the North West London maternity clinical strategy. We will work with NHS England and the local public health team to ensure that the commissioning of antenatal and new-born screening programmes is appropriately integrated with the commissioning of maternity services. We will review the model and funding of perinatal mental health services.

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3.12. Services for Carers – joint intentions

The CCG will continue to invest in services for carers, building on the work done in 2013/14, which has included the development of personal budgets for carers and for young carers. As part of its Equality Objectives for 2013-2017, the CCG will improve the rates of identification and support provided to carers and young carers, including within a primary care setting, and seek to offer appropriate support. The CCG will develop its plans in line with the intentions in the draft Care and Support Bill, which outlines the need to provide support services to carers, rather than simply identifying their needs

Some principles around support to carers include:

- The need to avoid carers telling their story repeatedly and ensuring continuity in support
- Developing a consistent definition of 'carer' across health and social care and the need for information sharing across partners
- Raising awareness of the needs of carers across pathways, programmes and services – not just considering them at a point in time
- Recognising the needs of carers across our all our commissioning decision making processes.

Progress to date

Our achievements include:

- The roll-out of personal budgets for carers via adult social care, with current levels of investments maintained in 13/14
- We have improved our identification of carers, including young carers. We have implemented the primary care navigator role as a 12 month pilot project, with one navigator working across six practices in the CCG to support increased identification and support of carers via primary care
- A Carers Hospital Discharge project has been initiated to identify and support carers via hospitals, supporting facilitation of timely discharge and information sharing.

Intentions for 2014/15

We will continue to maintain our investment in supporting carers, with support to young carers a key priority. We recognise the importance of working closely with partners and with organisations beyond health and social care, including education, in order to continue identifying and supporting carers.

Our specific intentions are to:

- Prioritise the identification young carers and the support for them. We will work with our LA colleagues, including education colleagues, on this. Specifically, we will develop a home-based family support service to support young carers

- Ensure/maintain appropriate registers for carers, e.g. GP registers, and explore cross referencing registers to proactively look for young carers

- Introduce Young Carers Personal Budgets with a new Tri-borough young carers provider

- Develop schemes to identify carers to health, social care and other professionals – to prevent them 'repeating their story' e.g. a 'carer's card'

- Provide training for carers

- Review the lessons from the primary care navigator role:

    - GP action plans to continue post-pilot

    - Understand how the learning can be applied to supporting carers in the virtual ward model of care, district nursing and other community settings

- Explore how we can address parking and transport issues for carers.

Measures of success in services for carers will include:

- Increased number of young carers identified through school education
- Increased numbers of young carers accessing support
- Identification & refer (signpost) systems embedded in pilot practices
- Completion of awareness raising training - e-learning by professionals
- Increased number of schools linked in with support services.

3.13. Public health

We have worked with our public health colleagues not only to understand the needs of our population, but also to understand their commissioning intentions and areas where we can work together and / or align our intentions. For example, we will:

- Work more closely with community champions, health trainers and the other community services that public health commission

The Tri-borough public health team based in Westminster provides support and advice and commissions a range of services. The functions of the service are set out in the table below.

Prescribed Functions (Mandated)		
Sexual health services – STI testing and treatment	Sexual health services – contraception	NHS Health Check programme
LA role in health protection	Public health advice	National Child Measurement programme
Non- Prescribed Functions (Discretionary)		

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Sexual health services – advice, prevention and promotion	Obesity – adults	Obesity - children
Physical activity – adults	Physical activity – children	Drug misuse – adults
Alcohol misuse – adults	Substance misuse (drugs and alcohol) – youth services	Stop smoking services and interventions
Wider tobacco control	Children 5 – 19 public health programmes	
Miscellaneous Functions		
Non mandatory elements of the NHS Health Check programme	Nutrition initiatives	Health at Work
Programmes to prevent accidents	Public mental health	
General prevention activities		
Community safety, violence prevention & social exclusion	Dental public health	Fluoridation
LA role in surveillance and control of infectious diseases	Information and Intelligence	Public health spend on environmental hazards protection
Local initiatives to reduce excess deaths from seasonal mortality	Population level interventions to reduce and prevent birth defects (support role)	Wider determinants

We intend to extend some of our existing contracts in 2014/15 as we work through the procurement timetable that has been developed and approved by Cabinet Members for public health in the 3 boroughs.

In line with this plan, we are in the process of re-commissioning the following services: Stop Smoking Quits and Prevention, reducing reoffending, reducing reoffending in women, SMS Group Work, SMS Primary Care Support, Club drugs project.

In 2014/15 we intend to review, commission or re-commission the following services: Childhood Obesity, Young People Sexual Health, Third Sector: Market Development, Domestic Violence, GUM Services, HIV Services, Core Alcohol Programme, Core Drugs Programme, Community Sexual Health & Reproductive Health, Third Sector: Health Improvement for Specific Population Groups, School Nursing, Healthy Schools Partnership,

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Detox Framework, Cardiovascular Disease Prevention, Peer Led Programme and the Health Improvement & Exercise Referral programme.

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4. Provider impact analysis

The purpose of this section is to flag for providers the scale of change associated with our commissioning intentions and the provider sectors where we expect the changes to impact.

This is a draft high-level analysis which shows the scale of savings associated with our 2014-15 QIPP plan. The table shows indicative savings matched against the sections described in more detail in the commissioning intentions. There will be savings generated as a results of more integrated working (section 3.1) but these have not been highlighted explicitly in this table because integrated working is an enabler that will cross-cut all of the above schemes.

These figures will be revised over November to give a second, more detailed and accurate cut, at the end of November based on the working of the task & finish group.

			Savings						Investment					
Document section	**Commissioning Intention**	**Savings (£000)**	**Primary Care**	**Community**	**Mental Health**	**Acute**	**Residential & continuing care**	**Volunary Sector**	**Primary Care**	**Community**	**Mental Health**	**Acute**	**Residential & continuing care**	**Volunary Sector**
3.5	Emergency Care	£5,207				-								
	Unscheduled Care	£3,187				-			+	+	+			+
	Average length of stay (Excess bed days)	£120				-				+				
	Acute schemes	£1,900				-								
3.3	Nursing and Residential Care	£500					-						+	
3.6	Planned Care	£1,611				-			+	+		+		
	Oupatient activity	£1,421				-			+	+		+		
	Elective Activity	£190				-						+		
3.7	Primary Care	£810	-						+					
	Prescribing	£810	-											
	Enhanced services	£0	-						+					
4.1	Community Services	£660		-						+				
4.2	Mental Health Services	£615			-				+			+		
4.4	Children's Services	£43				-			+			+		
	Consolidation of contracts	£600	-	-	-	-	-	-						
	Total	£10,046												

5. Procurement intentions

The purpose of this section is to highlight for providers those service areas where we intend to undertake procurements for services. This includes both existing services where current contracts are due to expire, and new investment areas where we anticipate that we can best deliver improvements for patients through an open procurement. The service areas and indicative timings for when the procurement process will commence are shown below. We are publishing this list to enable providers to best respond to our commissioning intentions but reserve the right to add or remove services or amend timetables should this be in the best interests of patients.

Service area	Indicative annual value £000s	Indicative procurement commencement date
Existing services		
111	TBC	TBC
GP out of hours	TBC	TBC
Wheelchair services	TBC	TBC
Community MSK	TBC	TBC
New services		
Children's Integrated Care Service	TBC	Q3 2014/15
Mental Health	TBC	Q3 2013/14
Primary Care access	TBC	Q3 2013/14

[DN – further content on procurement is to follow]

6. Enablers

[DN – further content on enablers is to follow]

We are investing in the following areas to enable the delivery of our commissioning intentions:

6.1. Engagement with patients, carers and users

As part of a collaborative-wide initiative, we have been working with patients and wider stakeholders to develop a patient experience strategy to inform decisions for commissioning compassionate, safe and effective care.

Next steps will be to:

- Facilitate co-design workshops with providers, service users and patient and community groups to develop a patient experience framework that will enable commissioners and local providers (health and social care, including third sector) to capture, act on and evaluate the impact of patient experience

- To work together with neighbouring CCGs within the CWHHE Collaborative and invest resources:

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- In ensuring that all Patient Experience data and community intelligence reflects the diversity of the local population and is collated, analysed and presented in a manner that is transparent and accessible to providers, patients, communities and the public.
- In presenting back – through 'You said.. We did' – to patients, partners and providers how their feedback influenced CCG decisions.

Our work on embedding equality into the commissioning of health services is underpinned by engagement with our staff, stakeholders. We believe that engagement with and drawing on the expertise of residents, patients, services providers and third sector organisations, is critical in shaping services that are of high quality, value for money and reflect the needs of our diverse populations.

6.2. People and organisational development

[DN – further content to follow]

We will invest resources to develop and deliver a programme of Equality Training and support to the Governing Body, staff and patient leaders to embed equality considerations into the CCG Commissioning Plans and assurance processes.

Embed Equality in CCGs business planning. In particular, undertake and publish Equality Analysis of CCG Commissioning Intentions

6.3. Information tools

The CCG's strategy will be to continue to extend the principle of one electronic patient record across all settings of care. This is in alignment with existing and anticipated IT strategies published by the Department of Health and its associated bodies. As well as the local IT strategy currently under development for the whole systems implementation within the framework of Shaping a Healthier Futures strategy.

The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care:

- Level 1 - There is access to and two way information exchange within a common clinical IT system and a shared record between the GP and the care provider
- Level 2 - Where the above is not possible due to technical, operational or financial constraints that as a minimum, the respective IT systems in primary care and elsewhere are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards (or other common messaging standards) as defined by the Health and Social Care Information Centre (HSCIC)
- Level 3 - Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible particularly where patients are receiving care out of area.

The CCG will work towards the sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care community. It will seek to fully implement the recommendations of the Caldicott2 review around the sharing of patient records to provide integrated and seamless care. Specifically it will ensure that role based access control to electronic patient records in all settings of care is standard. Furthermore, it will facilitate a mechanism and appropriate forum to ensure the management and governance of data controllers in common once common patient records are in place.

The CCG will continue to have active participation in the NW London IT Forum of commissioning and provider organisations, working collaboratively across the whole health economy to implement an integrated approach to IT systems and information flows across the health and social care community and alignment of commissioning plans with IT solutions and vice versa.

More specifically the CCG will continue working with CWHHE CCGs to implement a single IT system across GP practices and several directly commissioned services where appropriate. Current and future providers will be required to work within the frameworks and opportunities that a single IT system across primary care can offer. This will be translated into more granular service specifications, service improvement plans and/or CQUINs where relevant. The overriding objective is to improve standards of care facilitated by the accurate, timely and appropriate information exchange.

The CCG will in addition focus on these areas:

- Continue working to improve the timeliness and quality of information sent to or accessible by providers from GP practices via clinical IT systems and to ensure the most up to date, relevant and accurate information is always sent.
- Continue working with providers to enable safer and more efficient electronic methods of communication between them and primary care, building on the previous work and solutions around real-time information CQUINs.
- Work with social services to develop an interface between IT systems and more robust information exchange within common information governance frameworks. Principally that all providers use the NHS number as the unique identifier of the patient for all services in order to integrate records.
- Informing and enabling patients to improve their understanding and access to their medical records and taking a proactive role in their own care through the use of technology solutions that will improve access to their own records and interaction with care providers. In effect, enabling self-care planning tools and solutions where appropriate and particularly targeted at patients with long term conditions.
- Developing tools for GP clinical IT systems to provide integrated systems and processes such as in common clinical templates, status alerts and searches that will highlight key patients requiring further attention. Providing a patient risk stratification tool within (rather than outside) GP clinical systems, integrating more closely with other IT systems where the patient may have a record.

In addition the CCG will seek to implement (or make better use of) during 2014/15 and the following years, strategic IT systems such as:

- Choose and Book and its replacement system e-Referrals
- Electronic prescribing system
- Coordinate my Care system
- Summary Care Record.

6.4. Estates

With the changes effective from 1st April 2013 Hammersmith and Fulham CCG does not own any estates assets. However, it is acknowledged that the delivery of high quality healthcare will require access to appropriate accommodation in locations which reflect the health needs of the population. Any changes to the estates profile in the locality must be driven by those health needs.

Hammersmith & Fulham CCG has three key priorities for estates development in 2014/15:

Estates Strategy - The development of an Estates Strategy which will involve:

- The mapping of capacity to the local health needs of the population
- The functional suitability and flexibility of each property from which services for the local population are delivered
- Specific gaps in capacity to address the needs of the new service delivery models
- Opportunities for future developments to support primary care and the delivery of new service models, in particular the vision for out of hospital care.

The CCG expects White City Collaborative Care Centre to open in the Spring of 2014. The CCG will continue to support the Centre and ensure service provision embeds itself in the new Centre.

6.5. Governance and performance management through networks

[DN – further content to follow]

7. Stakeholder engagement

This section sets out the work we have done to engage our stakeholders through the commissioning intentions process, and our plans to continue to work closely with others going forward.

How we have developed our commissioning intentions

We have ensured proactive and inclusive approach to the development of our commissioning intentions 2014/15, which meets the needs of its members, patients and the public.

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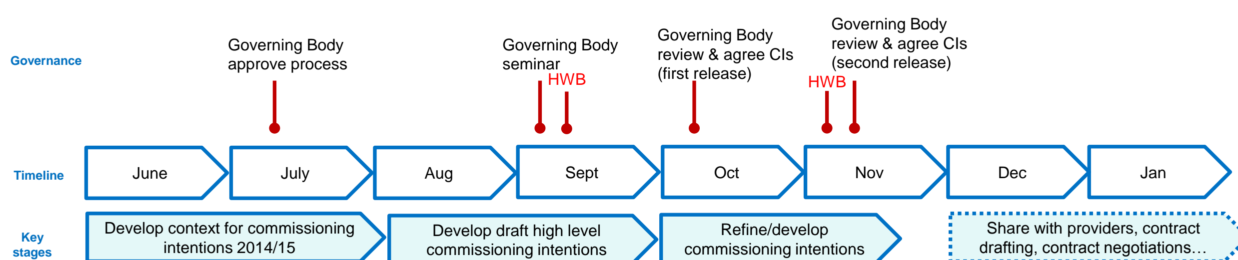
Figure 1 – Summary of the process for developing commissioning intentions



Stakeholder involvement has been fundamental to the development of our commissioning intentions. Stakeholders we have involved include:

- Hammersmith and Fulham CCG:
  - The CCG Governing Body
  - Network Leadership Group and individual networks
  - CCG membership
  - CCG management team.
- LA colleagues, specifically:
  - Adult social care
  - Public health
- The CSU Joint Commissioning team
- The Health & Wellbeing Board
- Patients and the public
- Community and voluntary sector colleagues
- CWHHE CCG Collaborative colleagues

Stakeholder workshop

A half-day event held on 26 September at the Queen's Club, West London. More than 50 attendees including:

- The CCG team
- Joint Commissioning Team
- CCG Governing Body
- LA
- HWB, including two local Councillors.

The workshop objectives were to:

- Develop support and engagement across the stakeholders involved in the commissioning process
- Be able to discuss and fill in the gaps in the draft H&F CCG commissioning intentions document

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- Share ideas on how to synchronise intentions across health and the local authority and work jointly together to achieve the targets set by Shaping a Healthier Future (SaHF), QIPP and the integrated care agenda.

The event included presentations from the CCG Vice Chair, group discussions on key areas of commissioning intent, key challenges and a focus on joint working between health and the LA.

Patient and public workshop

A half-day event held on 17 October with more than 70 attendees including:

- Healthwatch
- Range of community and voluntary sector patient representative organisations
- Patient group members, e.g. diabetes user group, older peoples' forum, Mind…
- The CCG team
- Joint Commissioning Team
- CCG Governing Body
- LA.

The workshop objectives were to:

- Share our draft commissioning intentions for 2014/5
- Gather feedback from patients and service users on what is working and what isn't so that we can shape our intentions further
- Get views on what the priorities should be

The event included presentations from the CCG Vice Chair and other Governing Body GPs, and group discussions on some key areas of commissioning intent (carers, mental health, urgent care and integrated care) and on what the priorities should be.

The Health and Wellbeing Board

The Health & Well-being Board have been specifically engaged in the process this year and we will build on this going forward, both in terms of delivering and monitoring the commissioning intentions and developing an improved planning process for commissioning intentions 2015/16. The Health & Well-being Board has been engaged in the process through a number of events as shown below.

Date	**Event**
9 September	**Health & Well-being Board** where the CCG made a presentation which aimed to provide: • An understanding of the overall development process and the underpinning principles • A summary of the key areas of commissioning intent for 2014/15 and their strategic fit • A summary of key strategic challenges • How these challenges determine the focus for

	2014/15 • A summary of further opportunities for involvement • Sight of the proposed content and structure of the commissioning intentions document
26 September	**Commissioning Intentions Consultation Workshop**, Queens Club. The purpose of the workshop was to: • Develop support and engagement across the stakeholders involved in the commissioning process • Be able to discuss and fill in the gaps in the draft H&F CCG commissioning intentions document • Share ideas on how to synchronise intentions across health and the local authority and work jointly together to achieve the targets set by Shaping a Healthier Future (SaHF), QIPP and the integrated care agenda
8 October	**Health & Well-being Board Workshop:** Discussion to enable a better understanding by the Board of how commissioning intentions relate to the JNSA and support HWB priorities
4 November	**Health & Well-being Board meeting:** Opportunity for the HWB to comment on the final document.

For the 2015/16 planning round, the CCG is seeking to understand how the HWB would like to be engaged in an on-going way, as well as at specific points in the planning cycle, which might include: decisions to decommission or re-commission specific services, the development of service specifications and the evaluation and monitoring of services. The CCG also seeks to agree how and when the Board will be involved in and updated on delivery of the commissioning intentions and the monitoring of progress.

This year's process has been focussed on the CCG commissioning intentions and on developing for the first time, some shared intentions with the LA. We would like to explore how we might encourage a broader debate across the public services in next year's planning cycle to encourage further collaborative work. The HWB could play a leading role in facilitating this process.

Stakeholder engagement going forward

[DN – further content to follow]

8. Conclusion

This document has set out the commissioning intentions for Hammersmith and Fulham CCG. They are intended to drive major transformation across the services that we provide to ensure that patients receive higher quality, more integrated care with an enhanced patient

experience. We expect providers to respond proactively to our intentions and to work with us to ensure our vision is realised.

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Appendix 1 – detailed provider impact analysis

[*to follow]*

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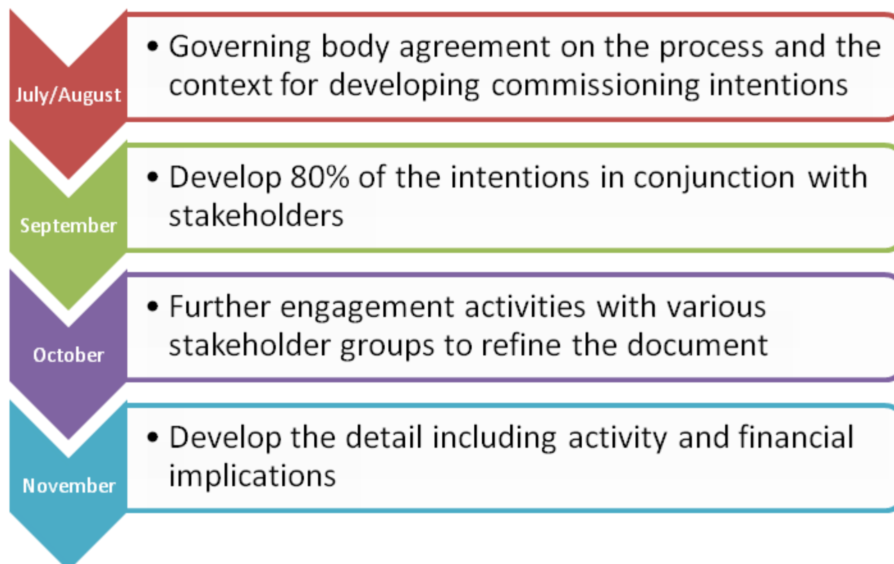
Appendix 2 – Process to develop commissioning intentions

[Set out the process and timetable followed by the CCG including dates, stakeholders engaged with etc]



Appendix 3 - FRAMEWORK TOOLKIT FOR LOCALLY COMMISSIONED OUT OF HOSPITAL SERVICES

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1. Purpose

The purpose of this toolkit is to assist CCGs in their decision making process for the commissioning of new locally commissioned out of hospital services, and to serve as a reference point when considering the appropriate procurement options for these services in the light of changes to the law since the Health and Social Care Act 2012 came into force.

The toolkit is primarily aimed at those services which were previously provided under a LESs in primary care.

CCGs need to balance the requirements of complying with the law and reducing legal challenge with the need to make effective and integrated commissioning decisions that are right for their local population. The aim of the toolkit is provide a framework that enables CCGs to do this quickly, efficiently and consistently.

Please note this does not constitute legal advice and does not replace the need for specific legal advice tailored to your individual circumstances.

2. Background

The Health and Social Care Act 2012 ("the Act") has brought in a new commissioning environment in which competition, patient choice and integration of services play a more prominent role.

At the same time, commissioning organisations have been restructured, with the creation of CCGs and NHS England. Primary care contracts are now managed by NHS England and in the light of this new guidance has been issued on the transitional arrangements for LESs.

This document is referred to as "Primary Medical Care Functions Delegated to Clinical Commissioning Groups: Guidance" (NHS England, April 2013).

NHS England has exercised its powers to transfer to CCGs:

- Management, on a transitional basis, of those local enhanced services for primary medical care and primary ophthalmic services that were originally commissioned by PCTs and for which responsibility has transferred to NHS England;
- Commission Out of Hours primary care services for their area; and
- Arrange GP Information Technology Services in their area.

At the same time, new regulations have been made that set out how the NHS should make decisions on procuring healthcare services, and inform the process CCGs should take to procure those services so as to reduce the risks of legal challenge. The full title of these regulations is the *NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013*, which have come into force under the Health and Social Care Act 2012. The general scheme of the Regulations is set out below.

3. NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 ("the Regulations")

The overall objective of the Regulations is described in Reg 2. These are:

- Securing the needs of the people who use the services;
- Improving the quality of the services; and
- Improving efficiency in the provision of the services.

In procuring health services, some of the principles which NHS bodies should adhere to in making decisions are described in Reg 3:

- Acting in a transparent and proportionate way;
- Treating providers equally and in a non-discriminatory way;
- Providing best value for money;
- Providing the services in an integrated way;
- Enabling providers to compete to provide the services;
- Allowing patients a choice of provider of the services.

TABLE A: GENERAL REQUIREMENTS FOR COMMISSIONERS

	Descriptor	Regulations			
Objectives	What commissioners should secure	Secure Needs of Health Users (Reg 2(a))	Improve quality of services (Reg 2(b))	Improve efficiency of services (Reg 2(c))	
Principles	How commissioners should act	Transparency (Reg 3(2))	Proportionality (Reg 3(2))	Non-discrimination (Reg 3(2))	
Factors	Considerations in decision making	Patient Choice (Reg 3(4)(c))	Competition (Reg 3(4)(b))	Integration Reg (3(4)(a))	Value for Money (Reg 3(3)b)

4. Transparency

Commissioners must ensure that they conduct all of their procurement activities openly and in a manner that enables their behaviour to be scrutinised.

Actions that commissioners could take to increase their transparency could include:

- Publishing information on their future procurement strategies and intentions;
- Taking steps to ensure that providers are aware of their intention to procure particular services;
- Publishing details of contracts awarded;
- Maintaining appropriate records of decisions that have been taken, with reasons.

5. Proportionality

The process put in place to procure a service must be proportionate to the value, complexity and clinical risk associated with the provision of the service in question.

There may be circumstances where the costs of running a competitive tender process would be greater than the benefits of doing so.

One possible solution where the cost of running a competitive tender process are disproportionate could be for the commissioner to announce an intention to award a contract on the Supply2health website so that other providers have a reasonable opportunity to express their interest in providing the services. In the event that the commissioner receives expressions of interest, it would need to consider what steps it should take to ensure that its engagement with providers is consistent with the requirement not to discriminate between providers.

6. Non-Discrimination

Commissioners are under a duty not to favour one provider, or one type of provider over another. Differential treatment between providers requires objective justification.

Potential behaviours which could be viewed as discriminatory include:

- Giving one provider a more extensive role in engaging with the commissioner on service design, which could then give that provider an unfair advantage ahead of its competitors;

- Not giving providers an adequate opportunity to express an interest in providing a service

- Designing the service specification in a way that excludes a provider or category of providers unnecessarily and without objective justification in terms of service needs, efficiency etc;

- If a competitive tender process has been followed, the award criteria must not disadvantage a particular provider if this cannot be objectively justified. The award criteria must be applied in the same way to all providers.

7. Value For Money

To comply with Regulation 3, commissioners must ensure that when they enter into new contracts they do so with the most capable provider or providers that provides best value for money. By common definition, this means:

QUALITY & PRICE

A provider will provides best value for money where it delivers the best overall quality and price (where prices are not set). *The best value will not necessarily be delivered by the provider that supplies services at the lowest price.*

Monitor have stated in their May 2013 guidance[1]that the factors they are likely to take into account when assessing whether commissioners have complied with Reg 3 are:

1.	Has the commissioner taken steps to identify existing and potential providers interested in and capable of providing the services being procured by the commissioner?
2.	Has the commissioner objectively evaluated the relative ability of different potential providers to deliver the service specification and to improve quality and efficiency?
3.	Has the commissioner required prospective bidders to undergo suitable due diligence, as appropriate?
4.	Has the commissioner considered both the short-term and long-term-impact of their commissioning decisions (including the sustainability of services)?
5.	Has the commissioner taken account of the effect of bundling services together?

8. Integrated Care

National Voices have worked with service user groups to derive a common definition of the meaning of integrated care. Under this definition care is delivered in an integrated way when

[1] *Substantive guidance on the Procurement, Patient Choice and Competition Regulations, Monitor 20th May 2013*

"*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".*

Many patients have complex health care needs and need to access a wide range of health-related and social care services. Where care is provided to a patient by a number of different teams from different disciplines, there is a risk that patient care will be fragmented or that there will be gaps or delays in care.

The aim of integrated care is to address these issues and resulting in better patient experience and may lead to improved clinical outcomes and more efficient health care.

Factors that might affect the ability of providers to provide integrated care might include:

- Physical distance;
- Differences in working practices;
- Differences in operating systems or IT.

Integrated care may be connected with quality and efficiency. Commissioners should therefore wish to require potential providers of services to demonstrate how the different professionals and teams that are responsible for different aspects of an individual's patient care will co-operate with one another and how the provider will co-operate with third party providers that are responsible for other aspects of an individual patient's care.

9. Choice and Competition

Competition may be based on two different forms:

a. Competition based on patient choice. This is where patients can choose between multiple providers of the same or similar services. Depending on the circumstances, patients may be able to choose between different NHS organisations as well as third sector or independent providers;
b. Competition for contracts to provide services. This is where providers compete for the right to provide a particular service, e.g. where the commissioner runs a competitive tender and selects a single provider for that service.

Under the NHS Constitution, health care service users have the right to choose their GP practice and to be registered by that practice unless there are reasonable grounds for refusal. Also under the NHS Constitution, patients have the right to choose the organisation that provides their treatment when they are referred for a first outpatient appointment for a service led by a consultant, subject to certain exceptions.

Commissioners need to demonstrate that they have considered the potential to allow patients a choice of provider by entering into contracts to provide a particular service with more than one provider. They should also demonstrate that they have considered the potential of competition to drive up quality or improve value for money, with reference to the particular service in question. Conversely, commissioners should consider the impact of

awarding a contract to a single or limited number of providers and the availability of credible alternatives.

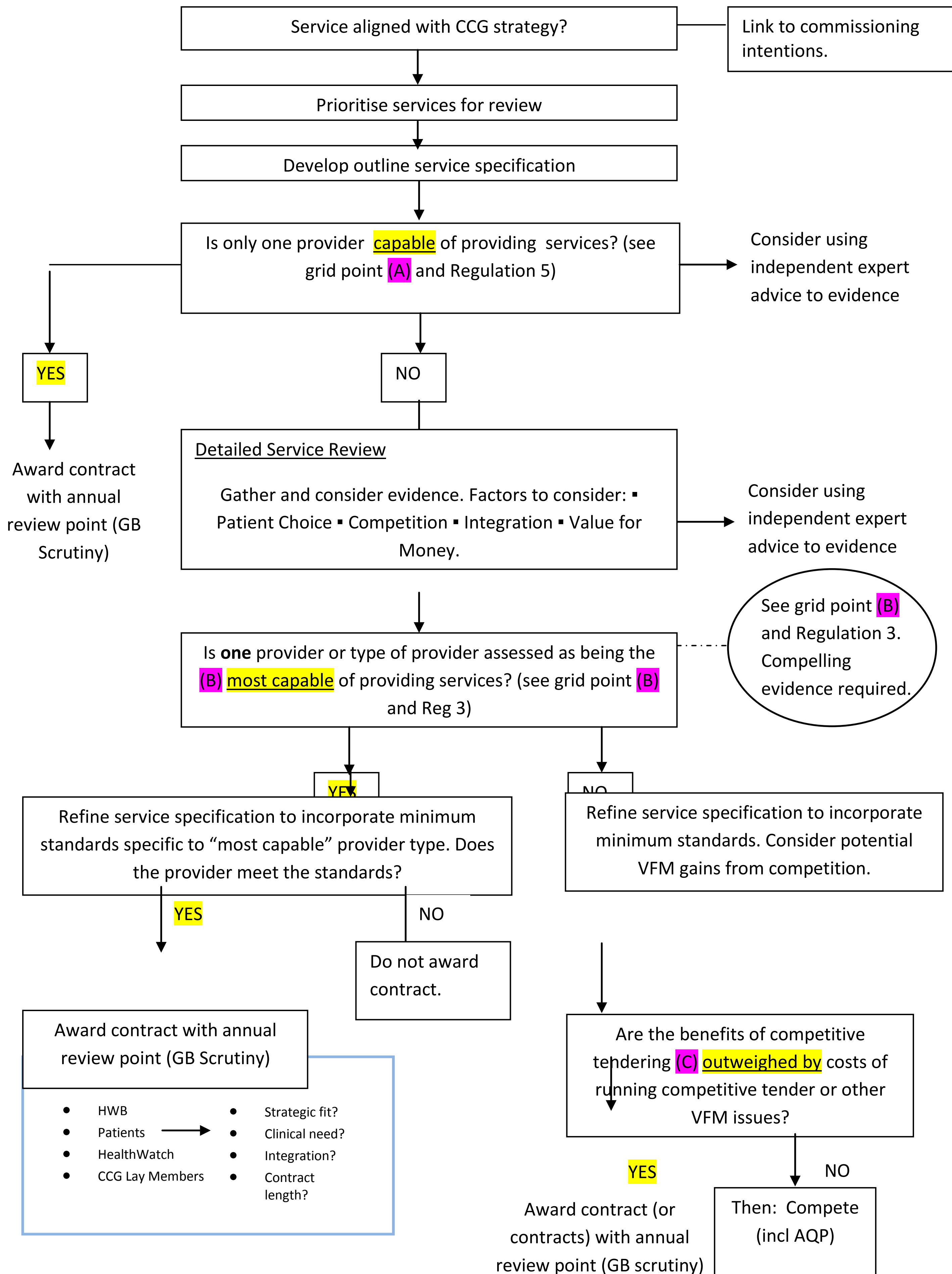
In assessing whether a commissioner has complied with its obligations, Monitor will look at the following factors:

1.	Has the commissioner appropriately specified the services to be provided to ensure that the relevant statutory rights have been protected?
2.	Do contracts entered into with providers responsible for making referrals to elective services impose positive obligations on providers to offer patients the relevant choices prescribed by law?
3.	What arrangements have commissioners put in place to ensure that health care users are aware of their rights of choice?
4.	What steps have commissioners taken to respond to any evidence (whether as a result of complaints or otherwise) that patients for whom they are responsible are not being offered the choices that are protected by these regulations?

10. Making Decisions About the Procurement Route

Having reviewed the service in question, commissioners will ultimately need to make a decision on the appropriate procurement route for an Out of Hospital contract. In some instances, there may only be a single provide capable of delivering the contract, and in these instances it is likely that the award of a single contract may be appropriate. In other circumstances, there may be several potential providers of the services in question, and commissioners will need to determine whether some form of competitive tender exercise is run, or whether a review process concluding in the award of a contract to a single provider would be more appropriate. A decision tree is set out on the next page as an aid for commissioners:

DECISION MAKING TREE FOR AWARDING OUT OF HOSPITAL CONTRACTS



EVIDENCE GRID

	Consideration	Action	Evidence
A	**Is Only One Provider Capable Of Providing Services?**		
	Guidance Note: Regulation 5 states that services are to be determined as capable of being provided by a single provider only when – (a) For technical reasons, or for reasons connected with the protection of exclusive rights, the contract may be awarded only to that provider; or (b) (only if it is strictly necessary) for reasons of extreme urgency brought about by events *unforeseeable by, and not attributable to*, the relevant body, it is not possible to award the contract to another provider within the time frame available to the relevant body for securing the provision of the services.		
	Consideration	**Action**	**Evidence**
(i)	Necessary Infrastructure (real or capable of development)	Ensure there is only one provider with a clearly defined infrastructure necessary to deliver the service and a supporting rationale for this. Draft Board paper with supporting evidence.	Service specification (volume and capacity, sustainability, location, equipment, staffing) Market analysis (from CSU or commissioned independently) of providers in the local market who could potentially provide the service, to include analysis of any risks to successful provision. An independent clinical expert review would provide strong evidence.
(ii)	Clinical advantages of co-location with other services	Ensure there is a strong case that only one provider has the necessary co-location to provide the services, with a clearly defined rationale as to why it is necessary to have co-location.	Define Service Specification. Utilise any evidence from Joint Strategic Needs Assessment or other Public Health reports that supports co-location. Set out the evidence that the service is interdependent with other services (the basis of the co-location). Even if co-location is required, consider whether this means the same provider has to provide the service, or whether several different providers could operate from the same site.
(iii)	Meeting immediate interim clinical need.	Demonstrate urgency of clinical need in report to CCG Board.	Set out circumstances leading to the immediate interim clinical need and demonstrating what the clinical need is. Ensure appropriate performance metrics

	Consideration	Action	Evidence
			are built into contract to monitor quality. Consider building in a shorter contract period if competition is still appropriate in longer term. Ensure contract is monitored thoroughly once in place to satisfy CCG that patient needs are being met.
(iv)	Publish/transparency (15-30 days warning on web site) prior to award.	Publish intent to award contract on CCG website within 15 – 30 days	Publish on CCG website, to demonstrate steps being taken to identify all potential providers.
(v)	Capacity for improvement	Define performance metrics and levels of potential increase towards benchmarked standards.	Set benchmarks for issues such as speed of response, potential for integration, sharing of clinical data, sustainability, patient safety and activity. This is particularly important in a 'monopoly' provider scenario where current service provision is below benchmarked standards. Publish results, set these out to demonstrate clear benefits for the patient.
(vi)	Conflicts of interest	Board must manage conflicts of interest effectively	Ensure all actions/ decisions have a clear audit trail and comply with CCG governance processes and evidence minutes/ papers/ CCG policies.
B	**Is only one provider or providers assessed as being the most capable of providing services?**		
	Guidance Note: Regulation 3 provides that the NHS must procure services from one or more providers that are: • Most capable of delivering the objectives in the Regulations (i.e. secure health needs, improve quality of services, improve efficiency); and • Provide the best value for money in doing so. When acting with a view to improving quality and efficiency in the provision of services the relevant body must consider appropriate means of making such improvements, including through – (a) The services being provided in an integrated way (including with other health care services, health-related services, or social care services);		

	Consideration	Action	Evidence
	(b) Enabling providers to compete to provide the services, and (c) Allowing patients a choice of provider of the services. Monitor's May 2013 guidance states: "In the context of the [detailed review], the commissioner may be able to identify with reasonable certainty those providers that are capable of providing the services…..In these circumstances it may appropriate to negotiate with those providers". Note that even if one provider could be assessed as the most capable, there is still a need to consider whether competition and/or patient choice would offer additional benefits.		
B.	**Consideration**	**Action**	**Evidence**
(i)	Service user needs and requirements.	Gather evidence around service user needs and incorporate into report to CCG Board, supporting case that provider or groups of providers are most capable.	Include in report evidence from: - Joint Strategic Needs Assessment - Public Health Information or reports - Consider national and local service models which may best serve those needs, with clinical input as required - Any recommendations of local clinical network - Any relevant NICE guidance - Evidence of standards of existing service provision (if any) from contract monitoring reports - Compare existing standards of service provision with any benchmarked national standards (e.g. NHS Benchmarking Network reports) and gap between current provision and benchmarked standards - Define appropriate service metrics for new service and scope for improvement. - Develop service specification for the service. - Demonstrate how the above supports the case that the provider or group of provider you have selected "most capable". - Make report available on CCG website.

	Consideration	Action	Evidence
(ii)	Is the service the provider is offering compatible with other services?	Review service and establish key points of service compatibility. Consider using a recognised expert to identify interdependencies.	- Collate and consider any national or local care pathways which include this service area, and the desired service specification. - Consider any appropriate clinical guidance covering the service area and its recommendations on which services should be interdependent on each other. - Review any current service providers and how they are interdependent on other local service providers. - Consider how the offering of the proposed service provider or providers would interact with any other services where an important interdependency has been identified. Compare this with any competing providers. - Take into account supporting IT infrastructure and care pathways offered by proposed provider(s). - If supported by the evidence, build a case that the proposed provider/s are most capable based on their compatibility with other interdependent services. - Consider engaging a recognised expert to identify the clinical interdependencies and support choice of "most capable" provider or group of providers. - Prepare report and seek agreement of CCG Board. - Make report public on website.
(iii)	Engagement and consultation.	Consult with key groups on the award of the contract to a provider or groups of providers.	Consider consultation on the award of the contract with key stakeholders such as: - Health and Wellbeing Board - Local Healthwatch - Local clinical networks - Collected views and feedback to prove capability.

	Consideration	Action	Evidence
			Sufficient information on the proposal should be provided to the groups to allow informed feedback.
(iv)	“Bundling” of clinical services (i.e. procurement of several different services from one provider as a “bundle”)	Consider and justify if “bundling” (i.e several services from same provider) is clinically necessary and document in report.	Consider whether bundling is clinically necessary. This involves considering questions such as: - Does the patient need to access the service from the same site as another service? - Does the patient need to receive the service in a particular setting? - Would opting not to bundle services impact on the *sustainability* of a provider to deliver other, related services (for example if it makes it financially unviable)? - Would achieving ‘economies of scope’ through bundling mean better value for money? - Would bundling result in the exclusion of the most capable provider (i.e. most capable provider of one part of the bundle cannot provide another part of the bundle), thereby preventing the best provider being chosen? - If a service needs to be provided to patients on a single site co-located with other services, is there a possibility it could be provided by *several* providers operating from the same site? - Publish rationale on CCG website and regularly review contract during its lifetime to consider whether the rationale still stands. An external, independent clinical view justifying “bundling” is likely to have the most weight.
(v)	Patient choice	Consider whether increasing patient choice is likely to have a positive impact on service	Demonstrate that the effect of patient choice on service quality is being considered and managed. - Consider impact of single contract

	Consideration	Action	Evidence
		quality. Check action is consistent with CCGs' policies on choice and the NHS Constitution.	award on availability of alternatives for patients in the future; - Document quality requirements for the contract and consequences of any breach and the duration of the contract. - Document rationale for the procurement route (e.g. Board Executive papers); - Require potential providers to demonstrate how different professionals and teams that are responsible for different aspects of an individual's patient care will co-operate with one another (where a provider provides more than one service) and how it will co-operate with third party providers; - Where appropriate, incorporate contractual terms requiring multiple providers to share patient records and manage physical transfer of patients between sites.
(vi)	Network or group of providers as "most capable provider".	Consider whether a network or group of providers offer improved value for money or economies of scale, rather than contracting individually with single providers.	Evidence of proposed structure of legal entity of network or group. Document any submissions made by proposed network and consideration of benefits that are likely to accrue from such an arrangement. National or local evidence from other areas may exist to support the benefits of such arrangement - if so document this evidence and write supporting rationale. Could a network have benefits in terms of sharing skills or continuity of care pathways? Gather feedback from proposed network on benefits they might be able to offer. If alternatives to the network exist, consider announcing decision to buy from network on CCG website so that other categories of providers are aware of its intentions and able to express an interest in supplying services themselves.

	Consideration	Action	Evidence
(vii)	Conflicts of interest	Board must manage conflicts of interest effectively	Ensure all actions/ decisions have a clear audit trail and comply with CCG governance processes and evidence minutes/ papers/ CCG policies.
C	**Are the benefits of competitive tendering outweighed by the costs of running competitive tender or other VFM issues?**		
	Guidance Note: The Monitor May 2013 guidance asks commissioners to consider whether the benefits of non-competitive behaviour outweigh the costs. It states "Commissioners will need to determine on a case-by-case basis whether the costs of a competitive process would inevitably outweigh the benefits that could be achieved, or whether the process could be adapted so that it both secures the benefits of a contested process and is proportionate to the nature of the services being procured." The guidance suggests a decision not to compete is more likely to be appropriate where the degree of clinical risk inherent in the service is low and/or the monetary value of the service is low.		
C	**Consideration**	**Action**	**Evidence**
(i)	Proportionality test	Actions must be proportionate to the value, complexity and clinical risk associated with the provision of the service Ensure you measure the amount of resources committed to procurement process compared to the value of services provided	Estimate of the costs of the procurement process. Compare with likely contract value of services provided. Commissioning intentions and priorities – do these match with the decisions for this service? Include this information in Board Report justifying the procurement route.
(ii)	Assess value	Take into account all aspects of Value, including tender cost, patient flows (i.e. are there	Factor costs/benefits analysis into Board Report and consider publishing on CCG website.

	Consideration	Action	Evidence
		sufficient patients that would wish to access this service?), and costs incurred by provider in preparing bids.	
(iii)	Assess clinical risk	Conduct risk evaluation using clinical expertise. Ensure that impact of any relevant reconfiguration exercises are taken into account	Demonstrate that the clinical risk is low (higher risk services point towards a procurement because there is a need to closely examine competing offers on service quality)
(iv)	Case by case testing	Select random case examples to confirm low impact by value and clinical impact.	Publish sample size to demonstrate volume of testing
(v)	Conflicts of interest	Board must manage conflicts of interest effectively	Ensure all actions/ decisions have a clear audit trail and comply with CCG governance processes and evidence minutes/ papers/ CCG policies.

The flow chart above has been drafted for the commissioning of health care services and is based on the CCGs' obligations under the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and Monitor's consultation guidance dated 20 May 2013.

11. CCG Standing Financial Instructions

Where a contract is to be awarded without seeking quotations or inviting bidders to tender, the tender waiver process set out in the Standing Financial Instructions must be complied with (see SFI 7(h) for specification as to the waiver requirements).

12. Contracts Relevant to the European Union

Where a contract could attract cross-border interest from countries within the European Union, different considerations would apply. Under this scenario the Public Contracts Regulations 2006 would affect the contract and the rules for Part B services would need to be followed. This would mean the contract would need to be advertised. Many Out of Hospital contracts will not attract cross-border interest but some of the larger value contracts (for example pathology services) could potentially attract interest from abroad.

13. Documenting Decisions

One important pointer to bear in mind is that decisions by CCGs to award contracts should be formally documented with reasons. A sound argument for selecting a particular procurement route and/ or provider can reduce the risk of challenge. Additionally, Reg 3(5)(b) requires CCGs to keep a record of how in awarding that contract it has complied with its duties as to effectiveness, efficiency etc and to improve the quality of services.

14. Publication of Contracts Awarded (Reg 9)

Regulation 9 requires commissioners to maintain and publish a record of all the contracts that they award on the website maintained by NHS England for this purpose. This is currently www.supply2health.nhs.uk.

Details to be included in the publication include:

- The name of the provider that the contract has been awarded to;
- A description of the services to be provided;
- The total amount to be paid under the contract;
- The dates between which the services will be provided;
- A description of the process adopted for selecting the provider.

15. Enforcement

Monitor has been given the power to investigate complaints that it an organisation has not complied with the Regulations. Monitor does *not* assess compliance with general procurement law (i.e. Public Contracts Regulations 2006) but, of course, commissioners must still ensure that they comply with these rules if they are relevant to the contract.

Monitor's Powers

Monitor can:

- Investigate a complaint of non-compliance by a third party;

- Request information from a be given information by NHS England or CCGs about the subject matter of an investigation;

- Set aside a particular term of a contract if it restricts competition, is not necessary and is "sufficiently serious";

- Set aside a contract if NHS England or a CCG has not complied with certain parts of the Regulations and the failure is "sufficiently serious";

- Direct NHS England and CCGs to do certain things, including ordering action to comply with the Regulations, directing commissioners to vary arrangements or contracts for service provision or directing a commissioner to pay for a bidder's loss or damage.

APPENDIX A: Summary of Key Obligations in NHS (Procurement, Patient Choice and Competition) Regulations 2013

Do the Regulations Apply?	What to build into your commissioning strategy	When must you open up to competition?	What must you do as part of your tender?	What records should you be keeping?
The Regulations apply to NHS England, CCGs and any other organisation providing procurement support. The Regulations also apply to CSUs.	How decisions are reached regarding the potential market for a particular service. How a procurement will improve quality and efficiency in the service. Consider if there could be any conflicts of interest or potential conflicts and if so ensure there is a robust process for dealing with them.	You should open up to competition unless: • Only one provider capable of providing the services; or • A detailed review has been carried out and a provider can be selected as the most capable, with reasoned justification and reference to the objective and principles in the Regulations; or • The costs of a procurement would outweigh the benefits to be obtained from competition (please see decision tree).	Advertise on *Supply2Health*. Include in the advert a description of the services and the evaluation criteria. Ensure you have put in place arrangements for providers to express an interest in a contract. Ensure your qualification criteria and any other criteria to establish a framework or AQP list is transparent, proportionate & non-discriminatory. Ensure your contract does not include any anti-competitive provisions unless necessary to achieve beneficial outcomes or the first objective. Publish on *Supply2Health* the following information about each contract: • Name and address of provider • Details & date of service provision • Value of contract • A description of the process followed	A full audit trail of any decision to procure a new contract, with reasons. Reg 3 (5)(b) requires CCGs to maintain a record of how in awarding the contract it complies with its duties as to effectiveness, efficiency and improvement in quality of services. Your process for ensuring you do not engage in anti-competitive behaviour unless it is in the interests of patients How conflicts or potential conflicts were addressed in each process.