South West London
Merton Clinical Commissioning Group

Report to the Merton Clinical Commissioning Group Governing Body

Date of Meeting: Thursday 24th January 2013

Agenda No: 6.5 **ATTACHMENT 05**

Title of Document: Commissioning Intentions 2013/2014	**Purpose of Report:** For Agreement
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Executive Summary:

These Commissioning Intentions represent Merton CCG's commissioning plans for 2013/14. These plans have been developed from the draft Merton Integrated Strategic Operating Plan (ISOP), based on the Merton Joint Strategic Needs Assessment (JSNA) and developed with the CCG membership, partners and providers.

Key sections for particular note (paragraph/page), areas of concern etc:

The document is not an extensive list of commissioning intentions or a final set of commissioning plans. The plans lay the foundations for specific areas of change to be developed into implementation plans with partners and providers.

Earlier drafts of the Commissioning Intentions (CI) have been shared with:

- MCCG Governing Body at their seminar in October 2012
- MCCG GP Leads in November 2012
- MCCG Clinical Reference Group in November 2012
- Merton Executive Management Team and provider organisations.

The ISOP outlines the CCG's vision for future commissioning of high quality services, the execution of its statutory responsibilities and the management of its operational functions as a future CCG organisation and legal entity. The next iteration of the ISOP will be brought to the March governing body meeting, noting that it is a live document and will be refreshed in line with the CIs and the final Operating Plan 2013/14 submission.

Recommendation(s):

The Merton Clinical Commissioning Group Governing Body is requested to approve these intentions and the commissioning plan for 2013/14

Committees which have previously discussed/agreed the report: Merton Executive
Financial Implications: The commissioning intentions highlight the commissioning priorities for Merton, upon which financial plans will be drawn.
Implications for the Sutton and Merton Board or Joint PCT Boards: N/A The document relates to commissioning after the abolition of the PCT
Other Implications: (including patient and public involvement/Legal/Governance/ Risk/ Diversity/ Staffing)
Equality Analysis:
Information Privacy Issues: None
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) Publically available after approval.

Merton Clinical Commissioning Group

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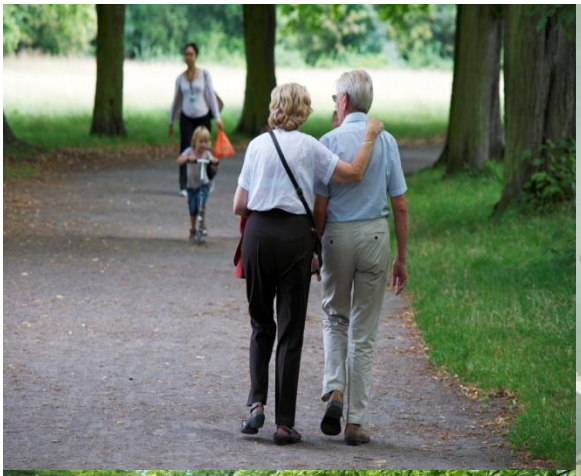
Commissioning Intentions

2013/14 (v1.13)






1. Introduction

These commissioning intentions from Merton Clinical Commissioning Group notify service providers of the priorities for 2013-14, as part of our Integrated Strategy & Operating Plan (2012- 13 and 2014-15). The intentions will be delivered by the CCG in partnership with the Local Authority & Public Health (London Borough of Merton), with support from the South London Commissioning Support Unit.

MCCG has worked through the commissioning cycle with our clinicians and members, and has implemented a voting process to identify the emerging priorities for 2013-14, based on the JSNA and other intelligence.

This is not an exhaustive list of commissioning intentions, nor is it a final set of commissioning plans. We expect to work flexibly with our members, partners and providers to generate specific plans and collaborative opportunities to improve the quality and efficiency of services for patients, as part of the commissioning and contracting cycle.

Our commissioning intentions reflect the key drivers in Merton's Integrated Strategy and Operating Plan (ISOP) which has been consulted on widely and reflect the Merton Health & Wellbeing Strategy.

Our eight strategic initiatives are:

1. **Long Term Conditions (Integrated Model of Health and Social Care)**
2. **Urgent Care**
3. **Mental Health & Learning Disabilities**
4. **Planned Care**
5. **Children & Young People**
6. **Staying Healthy & Prevention**
7. **Maternity & Newborn**
8. **End of Life Care**

We look forward to working with our colleagues across the health and social care economy to realise these commissioning intentions.

Signed

Dr Howard Freeman
(Chair Designate)

Eleanor Brown
(Chief Officer Designate)

2. Health Profile

Merton CCG will utilise the working relationships and knowledge available to us about Merton residents to commission services based on need and evidence based best practice. Colleagues in public health have supported this work and utilising the Joint Strategic Needs Assessment for Merton (JSNA), we know the following about our population.

Overview

Generally people living in Merton are very healthy; there is good life expectancy (exceeding the national and regional average) for both men and women. Merton has fewer people dying from conditions that could be avoided compared to the national and regional rates. In addition there are fewer people needing unplanned hospital admissions for diseases caused by smoking or alcohol or through suicide or unintentional injury, although the increase over time for some of these indicators is above regional or national rates.

Merton has significantly fewer children living in poverty than London as a whole and lower infant mortality, which is often used as a comparative measure of a nation's health and as a predictor of health inequalities. Currently there is less long term unemployment in Merton compared to national and regional rates and overall higher levels of employment, but the impact of the recession needs to be monitored on an on-going basis.

However, these apparently favourable measures mask significant variation within the borough from east to west. Life expectancy is a very good measure of overall health and inequality, and across Merton there is a significant difference in life expectancy between different communities within the Borough. Tackling health inequalities between East and West Merton remains a priority for commissioners, both in terms of targeting prevention, supporting vulnerable families and management of long term conditions to ensure greater quality of life and to reduce unnecessary hospital admissions. Effective measures to raise life expectancy in East Merton will focus on:

- Reducing smoking – targeting specific at risk groups where appropriate.
- Tackling obesity – including families and children – getting more people eating healthily and to be more active.
- Improving environmental factors such as housing and reducing the risk of accidents. By targeting the over 50s we aim to achieve the greatest short term impact on life expectancy will be made.
- More information can be found in our Joint Strategic Needs Assessment (JSNA): www.mertonjsna.gov.uk

3. Financial Context

High Level Financial Summary:

Our financial strategy has been developed on the understanding of the current and prevailing financial position and use of resources. Further development is required on benchmarking, care pathway and disease spend analysis, this is being done and commissioning intentions will be updated as appropriate in light of this. It should also be noted that during 2012-13, the CCG is working jointly with Sutton CCG to disaggregate the previous PCT finances across Boroughs.

Key Principles:

- Consideration of the context in which the CCG operates in terms of health care policy and strategy, and the impact of these influences
- Resources are prioritised to deliver the CCG's strategic objectives in line with our Commissioning Intentions as detailed within the Integrated Strategy & Operating Plan (ISOP)
- MCCG members: GP practices, local clinicians and managers work together to develop financial awareness, understanding and ownership of financial issues in the delivery and commissioning of services to deliver immediate and long term change, and that the finance function will support them in making the right choices and commitments
- The need to develop public engagement programmes to facilitate ownership of and best use of resources
- New investment and disinvestment reviews are focused on the change in health improvements delivered
- The underpinning financial processes need to be sufficiently developed to provide robust and complete financial information to assist in the delivery of the strategy.

A draft financial strategy is provided, as the financial allocation framework is yet to be finalised and moreover the precise detail of the distribution of existing resources to the National Commissioning Board, Local Authorities and Public Health England, is still outstanding.

Merton CCG for 2013/14 expects to receive growth funding of 2.3% on its resource limit, and this is anticipated to increase to 2.84% in 2014/15.

Delivering the financial plan from 2013/14 onwards, in the context of reduced and uncertain growth and in a period of significant transformation, will as a result be challenging and against this background the transition process is the largest financial risk facing Merton CCG.

Revenue Outlook

During 2013/14 and 2014/15 the CCG will experience considerable pressures primarily in acute but also in non-acute areas of spend, with consideration of the options outlined in the 'Better Services, Better Value Review' (BSBV) pre-consultation plan.

'Quality, Innovation, Productivity and Prevention' schemes (QIPP) are the key to unlocking the level of efficiency required. Achievement of QIPP plans is dependent upon local clinicians, primary care teams and managers working together to deliver both immediate and long term change.

This, in an ever increasing financially challenged environment requires that central to achieving financial balance, is also the continued requirement to maintain focus on contingency and surplus planning, careful financial planning and investment prioritisation through the delivery of significant, sustainable efficiency savings.

Continued investment will only be achievable if efficiency savings are created through service reviews and service redesign over and above that which is required to deliver financial balance.

The anticipated QIPP savings (gross) for the following years are as provided within the table below:

Merton 5 year QIPP Plan

QIPP Level 2 Categories	2012/13 GROSS	2013/14 GROSS	2014/15 GROSS	2015/16 GROSS	2016/17 GROSS
Mental Health	£251,350	£725,000	£250,000	£50,000	£50,000
Acute Sector	£1,682,312	£745,000	£400,000	£250,000	£100,000
Community Support Services	£502,700	£500,000	£500,000	£500,000	£500,000
Long Term Conditions	£1,228,520	£362,000	£362,000	£362,000	£362,000
Urgent Care	£2,665,366	£618,000	£618,000	£400,000	£200,000
Planned Care	£1,334,465	£1,976,000	£1,000,000	£1,000,000	£1,000,000
End of Life Care	£313,685	£0	£0	£0	£0
Prescribing	£502,700	£500,000	£500,000	£500,000	£500,000
Unidentified	£0	£2,995,000	£2,370,000	£2,938,000	£3,288,000
Other	£1,765,351	£0	£0	£0	£0
	£10,246,449	**£8,421,000**	**£6,000,000**	**£6,000,000**	**£6,000,000**

4. Commissioning Intentions (2013 – 2014)

1. Long Term Conditions (Integrated Model of Health and Social Care)

LTC has been voted the number one priority by Merton CCG members and is a priority within the local Health & Wellbeing Strategy. The model of care for people with LTCs applies to the care of adults, including frail elderly people, with a specific focus on supporting people with one or more Long Term Conditions.

The model of care includes patients with Learning Disabilities, dementia and/or mental health problems, for whilst there are already services in place to support these clients, there is a high prevalence of people experiencing anxiety and/or depression, calling for the need for more integrated services such as psychological therapies. The model will be based on risk stratification tools to identify people who are most at risk of being admitted without a case management approach to supporting their needs. The proposed model of care seeks to achieve a whole system approach to delivering Out-of-Hospital care, including primary, community, mental health and acute health care services with social care and the voluntary sector.

Learning from 2012-13:

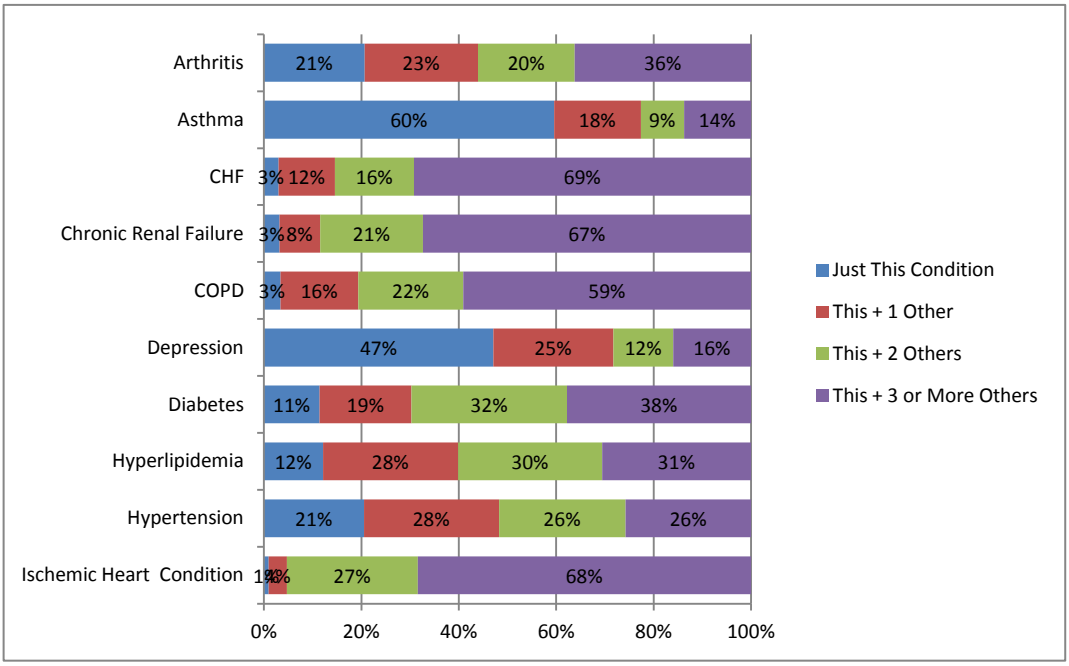
During 2011/12 Sutton & Merton PCT launched a range of innovative initiatives around Long Term Conditions, from tele-health to risk stratification, including dedicated working and steering groups.

- MCCG learning for 2013-14, is that the risk stratification project needs sufficient resources and prioritisation if we are to transform the model of integrated health and social care for people with LTCs.
- Older People's Assessment and Rehabilitation Service (OPARS) – explore scope to review and build on this service to maintain the health of older people and prevent unnecessary hospital admissions.

- MCCG has developed a new model of commissioning with secured funding to pump-prime the implementation shared across provider organisations.
- 5 key commitments underpin the transformation of the local model of care with partners and providers; collaboration, governance, clinical safety, quality and managing financial risk.

In summary, our work from piloting risk stratification across 5 practices, as below, shows there are a significant number of people with co-morbidities whose health and social care needs do not fit neatly into one pathway, highlighting the need for multi-disciplinary reviews and a case management approach and more rehabilitative services in the community.

Patient profiles of multi-morbidity across 5 Merton practices:



Key Priorities:

Merton's Clinical Reference Group and multi-disciplinary LTC Network will oversee the implementation and partnership sign-up to the principles of system transformation and an operational model of integrated health and social care.

The **model of care** includes:

- Roll-out of risk stratification across participating practices
- Adoption of Coordinate My Care where possible for people with LTCs
- Development of multi-disciplinary team meetings for case reviews
- Engagement of providers in case management system
- Development of health and social care performance dashboard.
- Establish and agree inter-provider clinical governance framework.
- Enablers: Pump-priming resources to be made available to contribute to increased operational costs, above existing service investments. Introduce contract mechanisms via LES, community/acute contracts and QoF.

Other key developments:

As part of the model there is a need for the following developments:

- Review rehabilitation pathways of care and shift into the community; primary, secondary care and social care.
- Establish 3 Intermediate Care Teams to support and case manage people with LTCs.
- Use Section 256 funding, to enable GPs to refer to local reablement services, enabling people to remain in the community and avoid admissions and readmissions.
- Pilot an urgent care service in the community, offering 2 hour assessments, to prevent non-elective short stay admissions – for more detail please see Urgent Care.
- Utilise the learning from our commissioning of OPARS, to develop a one-stop shop access to holistic assessments and diagnostics in the community, to maintain the health of older people and prevent unnecessary hospital admissions.
- Review workforce skill mix to deliver the new model of care in the community.

Alongside these priorities, we will also consider:

- options for Telehealth for patients with COPD or heart failure – to prevent exacerbations and emergency admission rates.
- COPD Met Office Alerts – provide patients with automated telephone calls during adverse weather to manage exacerbations and avoid unplanned admissions.
- Merton Carers Delivery Plan – joint plan produced with Merton Carers Centre.

Dementia – MCCG also considers dementia a LTC and has identified with the London Borough of Merton the following priorities:

- Raising awareness about dementia and provide access to information regarding the range and quality of local services available. This includes the following commitments:
- Ensuring people with dementia/their carers have access to good quality early diagnosis/intervention, as well as post diagnosis support and promotion of independence as part of an integrated care pathway
- Improving quality of care within general hospitals and that people with dementia are living well within care homes
- Appropriate prescribing and use of antipsychotic medication is taking place within clinical and care home settings
- Strengthening commissioning and partnership working between the local borough of Merton and NHS Merton
- All commissioning raises dementia awareness

Provider Impact:

Primary Care	• Increase case management, with a progressive roll-out of the model in the 3 localities • Participation in risk stratification and the resulting case management • Ongoing improvements in screening and detection of LTC
Acute	• Reduced level of unnecessary admissions to Hospital, particularly for ambulatory care sensitive conditions, requiring cross CCG and Acute negotiations on short stay / escalation beds

Community Services	• More responsive community services piloting a new model of care. The model of care will require new ways of working for acute, community, nursing, physio and Occupational Therapy teams with the Local Authority • The CCG will require on-going assurance from Royal Marsden Foundation Trust (RMFT0 that workforce development needs and skill-mix are supported through CPD • Development of Intermediate Care Teams by reshaping the functions and footprint of existing community services • Community Services will be required to participate in the review of Intermediate Care Teams and agree action plans for any changes following outcomes of the review
Social care, mental and community health care services:	• Participation in multi-disciplinary case management for patients with the most complex needs • Development of GP referral pathways to reablement services commissioned by the LA • All – development of inter-provider clinical governance frameworks across providers

MCCG organisational goals – anticipated benefits/outcomes:

Right Services	• Improved clinical outcomes for patients through integrated care • Improved preventative and self care • Working with the Local Authority (through the use of Section 256 funding) to enable GPs to refer to local reablement services to enable people to remain in the community • Avoid admissions and future readmissions.
Right setting / Right time	• Reduced duplication of services and multiple assessments (health and social care) • Leading to improved patient satisfaction and quality of life • More patient are treated in the community as an alternative to hospital
Right Outcomes	• Improved outcomes of care (i.e. condition management) at lower cost • Prevention of complex co-morbidities becoming chronic acute dependent conditions improved wellbeing of patients, particularly in management of associated mental health needs (i.e. depression and diabetes / anxiety and COPD)
Transformation and productivity	• The shift of care into the community will result in reduction in bed days, emergency admissions and readmissions, enabling acute sector to focus on resources for patients who need acute care. • This should reduce the operating costs of services for all partners – primary care, community, social care, mental health, acute.

Anticipated financial impact on provider SLAs (2013-14):

There is no additional recurrent funding in place beyond the initial LTC pump-priming (2012-13). If successful, the transformation should be sustained through transferring contractual investments in acute services into the community. Assumptions:

- A reduction in acute activity growth levels based on actual reduction in short stay beds to enable re- provision in a community model of care.
- Re-provision provides the opportunity for existing community and acute service providers to explore lower cost community settings.
- Collaborative QIPP model will provide efficiency savings to the CCG, with reduced overall levels of investment across both contracts, based on:
  - Greater acuity in patient contacts (and use of innovation to reduce operating costs i.e. more patients treated in lower cost settings).
  - Reduced operating costs and activity levels (i.e. reduction in admissions/higher cost settings), means reduced investments and cost base.

2. Urgent Care

Merton CCG is in the process of transforming urgent care services for local residents. This includes the integration of two Urgent Care Centres at St George's and St Helier Hospitals, with the implementation of a new 111 services and Out-of-Hours service.

Key learning from 2012-13:

Our model of urgent care service should be part of the integrated model of health and social care, including risk stratification multi-disciplinary reviews and pro-active case management of patients. This will result in:

- Fewer unnecessary admissions through the development of urgent care services in the community
- Provide more same day in-hours access to Primary Care for minor conditions, as an alternative to complement Urgent Care Centres, providing services closer to home for patients.
- More patients' needs met through community services and a reduction in the growth of A&E attendances/short stay admissions e.g. for ambulatory care sensitive (ACS) conditions.
- Actively managing patients with ACS conditions through vaccination; better self-management, disease-management or case-management; lifestyle interventions to prevent acute exacerbations and reduce the need for emergency hospital admission.
- Promotion of independence by preventing inappropriate/avoidable hospital admissions, maximise rehabilitation/recovery after illness or injury, minimising premature dependence on long term institutional care.

Key Priorities:

- **An urgent care service response in the community with admission prevention assessments, e.g. with target response times of:**
  - Urgent referrals – within 2 hours (Monday to Friday 8.00 am - 6.30 pm) to prevent unnecessary admission to hospital.
  - Non-urgent referrals – within 4-8 hours i.e. for all other referrals (e.g. supported discharge).
- **Prevent avoidable admissions to hospital from nursing and residential care homes, through the roll-out of virtual care home initiative.**
- **Prevent premature admissions to long-term residential/nursing home care, as well as emergency social care packages:** MCCG aims to reduce future emergency re-admissions within 28 days through the on-going development of integrated reablement services with the Local Authority (via Section 256 arrangements).
- **Urgent Care Access to Primary Care:** Reduce A&E attendance rates *during* core GP hours (i.e. 08:00-18:30) through each locality reviewing same day access for patients in Primary Care, with the opportunity for a LES. A new Out of Hours service for 2013/14 will be launched following procurement. Reduce A&E attendance rates *outside* core GP hours (i.e. 18:30-08:00) through continued close working with local Urgent Care Centre's at St Helier and St Georges NHS Trusts.
- **MCCG will continue the roll-out of the following services:**
  - **111** will go live in November 2012 ensuring more patients can be treated closer to home in primary care (General Practice, Urgent Care Centres and Pharmacies).
  - **Ambulatory Emergency Care**: MCCG will continue to commission ambulatory emergency care pathways with local acute hospitals.

Provider Impact:

Primary Care	• Divert more resources to Primary Care to meet demand for same day access • Review operational resources to implement morning telephone triage for patients – Enhanced Primary Care Services.
Community	• Development of urgent care services in the community - MCCG may commission a pilot service for the best potential provider. • Reshape into 3 Intermediate Care Teams across 3 localities, starting in 2012-13 with full roll-out in 2013-14.
Acute	• Impact of strategy with partners, will reduce the growth and need for short stay beds in Hospital i.e. reduced acute footprint. • Improve same day access to primary care and reduce demand for A&E, by improving acuity of referrals to OOH services, as well as the number of people self-presenting at A&E. • Support Urgent Care Centre's as a setting for minor injuries and illnesses, also manage in-hours reductions in activity growth based upon improved access to Primary Care. • This will have a specific impact on St George's and St Helier, where the majority of our patients access Urgent Care Centre, A&E and short stay admissions.
Mental health	• Support the urgent care needs of people with co morbidities, including LTCs and depression/anxiety, by working with SW London & St Georges NHS Trust. • Mental health professionals will engage within a multi-disciplinary model involving District Nurses, Community Matrons. • Build mental health competencies as part of CPD (Continuing Professional Development).
Social care	• Fair access to care services (FAC) criteria for social care will result in more integrated care and less duplication of services, as a result of the integrated model of health and social care.
Medicines Management	• Improved access to Primary Care may result in increased prescribing levels in the community.

MCCG organisational goals - anticipated benefits/outcomes:

Right Services	• More effective OOHs services and the implementation of 111, with clear care pathways and referral dispositions. • The 111 service will ensure a greater level of acuity in referrals to the right setting of care, e.g. if patient requires consultant care, or if medical assessments and prescribing can be safely carried out via the telephone.
Right Setting	• Improved same day access to Primary Care. • Intermediate care services working with urgent care services in the community, offering rapid assessments, case management and community nursing interventions as an alternative to ambulance conveyance and admissions, where appropriate.
Right Time	• Offer appropriate level of clinical intervention, so that people are aware of the right services to access within the system. • Promotion of independence and self-care as an alternative to default A&E access.
Right Outcomes	• Ensure more urgent care needs are treated at home and in the community. • 111 to lead to greater acuity in out-of-hours services and that a higher percentage of patients receive appropriate face-to-face medical attention when needed.
Transformation and Productivity	• Development of new integrated services for 111, OOH and integrated model of care within a multi disciplinary approach. • Reduction in the growth in: A&E activity; Short Stay admissions; Length of Stay. • Reduction of service duplication i.e. multiple triage and assessment.

Anticipated financial impact on Provider SLAs (2013-14):

An overall shift of urgent care into primary and community settings where appropriate, in relation to patients' medical needs, as a result of our local urgent care 111 Directory of Services with appropriate pathways.

Acute: Implementation of 111 and OOH services, will influence patient activity flows in Urgent Care Centre activity and Emergency Departments (A&E where appropriate). The model of care for LTC will also impact upon short stay non-elective admissions across various conditions e.g. congestive heart failure, diabetes, asthma, angina etc.
Community: Increased demand for case management and urgent care assessments as an alternative to admissions.
Primary Care: Increased demand for Primary Care in-hours and Out of Hours services via referrals from 111.
Medicines Management: Increased demand for Pharmacies due to the promotion of self-care for minor ailments through 111.

3. Mental Health & Learning Disabilities

Mental health services will focus on accessible early intervention and prevention services and all services will treat people with dignity and respect and in the least restrictive environment.

Specialist Learning Disability community services are commissioned from the London Borough of Merton and from specialist NHS and Independent sector providers. LD services are included in this section as there is some overlap with providers who are commissioned to provide both mental health and LD services.

Learning from 2012-13:

MCCG will commission services that are co-produced and reconfigure mental health and LD services to ensure they are primary care focused and integrated to further reduce health inequalities and inequitable access.

Key Priorities

Primary Care

- Review care pathways to refocus services towards prevention and early intervention and integrate out of hospital care pathways with more specialist provision
- Review primary care workforce with a view to providing services currently provided by secondary care in a primary care setting
- Ongoing support for people with stable conditions via primary care key workers
- Integrated working with social care dual diagnosis/substance misuse support liaison
- Re-tender Improving Access to Psychological Therapies (IAPT) services by September 2013

Working Age Adults

- Review and redesign rehabilitation inpatient services
- Review commissioning arrangements and re-provide services currently provided at Norfolk Lodge by SWLStG within the independent sector

- Develop service specification via an Any Qualified Provider (AQP) process ensuring that quality standards are included and agree pricing mechanisms
- Review and agree ongoing clinical management arrangements mental health and LD specialist placements
- Review SUN Project and agree ongoing commission arrangements
- Reduce the level of activity within tertiary/specialist services as and where appropriate,
- Repatriate activity to local services as clinically appropriate
- Review carer support services

Older People's Mental Health Services

- Review older people's services and reconfigure or decommission if/where necessary
- Review the implementation of the Joint Dementia Implementation Plan and performance of memory services
- Review psychiatric liaison services with the aim of identifying any reconfiguration needs
- Consider opportunities to provide mental health expertise and/or training to general older people's services e.g. domiciliary care
- Review support services provided to carers and audit carer experience via appropriate methods e.g. telephone surveys
- Raise awareness about Dementia and provide people with Dementia and their career's access to; information re services
- Dementia Support Services – provide services in partnership with other health/social/third sector agencies providing pre diagnosis support and continuity of care, after diagnosis until the end of life

CAMHS

- Work with providers to reshape CAMHS services in order to mainstream aspects of piloted services such as the Multi systemic therapy programme that have been shown to work, as the first-line response to Conduct Disorder in Young People aged 12+
- Review and reconfigure Tier 2 services working jointly with Local Authorities
- Continue to improve access to CAMHS services by joint working with the local authority, schools and other agencies and commissioning the delivery of CAMHS interventions in general rather than specialist settings

Integrated Mental and Physical Services

- Support the needs of people with co-morbidities e.g. LTCs anxiety/depression through the integrated model of care – see LTC
- Review options for closer liaison between the older peoples Intensive Home Treatment Team and district nursing service and reconfigure/re-tender services if appropriate
- Promote closer working between SWLStG community teams and the Sutton and Merton community service

Special Contractual Placements

- Review workforce needs
- Implement a standardised needs assessment tool for people being placed in accommodation/residential services
- Reduce number on NHS funded placements in accordance with need
- Integrate continuing care and mental health placements functions as appropriate to facilitate shared learning and better economies of scale
- Identify opportunities for collaborative care pathway commissioning with social care

Cross-cutting priorities across client groups

- Identify opportunities to further develop voluntary sector service provision
- Improve communication between primary/secondary care (across all health areas)
- Review all voluntary sector spend, identify joint commissioning opportunities with Local Authorities and/or other CCGs – applicable across all client groups

Provider Impact

Primary Care	• More resources diverted to Primary Care • Services take on a central coordination role for mental health, to improve outcomes for service users • Ensuring that mental health care is integrated with physical health services and health inequalities are reduced
Community	• Resources redirected to provide more early intervention and preventative services in community settings. • Longer term care provision to be enhanced to ensure more activity is delivered within community settings • IAPT services will be tendered, with consideration of the overall development of community mental health services and the development of an integrated model of care for people with LTCs including mental health issues
Acute	• Reduction of activity within acute mental health settings locally. • Investing resources in preventative services
Mental health	• Care pathway reconfiguration plans likely to result in an increase in providers • Activity at a secondary and tertiary level will reduce further during 2013/14
Social care	• Continue work with the Local Authority to ensure access to • Reablement services for people with mental health issues and/or physical health needs, as well as direct GP referral to reablement services (Section 256).
Medicines Management	• Improved access to Primary Care may result in increased prescribing levels in the community.

MCCG organisational goals – anticipated benefits/outcome

Right Services	• Improved primary care and community high quality, accessible mental health services. • More effective early intervention and preventative services to support the reduction of people going into crisis Reduction in an over reliance of specialist (including secure) provision. Better integration of mental and physical health care • Streamlining referral routes into services and improving access to services for people from BME groups. • Improved health promotion work to support self-care and encourage early help seeking with regard to mental health issues.
Right setting / Right time	• Improved access and increased capacity in primary and community care settings • Integrated community care services offering early intervention, preventative services, facilitation of closer working with social care and 3rd sector services • Choice of provider and setting where appropriate and possible • Offering the right care, appropriate level of clinical intervention and a time and place suitable to individuals requiring intervention
Right Outcomes	• Reduce the number of people presenting in crisis to mental health services. • Agreeing recovery focused outcomes for all services that are effectively performance managed.
Transformation and activity	• Develop integrated mental health services within accessible community/primary care settings. • Reducing growth in use of tertiary and secondary care services; secure services; length of stay and optimisation of in-patient beds; Reduction of service duplication and better integration with social care.

Anticipated financial impact on provider SLAs (2013-14):

An overall shift of acute secondary and tertiary care spend across primary and community care settings focusing on primary care early intervention and preventative recovery focused service redesign. A further shift to other and/or new providers may occur as a result of retendering exercises, AQP and the review of older people's services. QIPP efficiencies where appropriate.

4. Planned Care

Learning from 2012-13:

- Optimising unnecessary routine follow-ups due to administrative issues can be achieved through GPs actively discharging patients
- Optimising GP referrals to secondary care outpatient services identifying the right model of clinical support for GP referrals to develop future referral pathways
- Waiting times for some specialties in the community e.g. physiotherapy services, can trigger referrals which could be triaged and managed in the community e.g. MSK
- On-going investment in LES to enable lower level interventions to be offered in Primary Care e.g. anticoagulation for stable patients; 24 hr blood pressure; information and exercises for neck and back pain etc.

Summary of initiatives:

- **Providing elective care closer to home**
  On-going repatriation of patients to primary care for anticoagulation (INR monitoring) as a LES and expansion of community consultant nurse-led pelvic floor service established in 2012
- **Lampton Road Facility (LRF)**
  Outpatient and Follow-up activity to be moved to LRF from various acute settings
- **Options for clinical referral support to Primary Care:** Carry out a clinically led review of the evidence base/models for supporting GP referrals e.g. telephony based Choose and Book services
- **Patient Navigation Project:** Project has resulted in a significant reduction in follow up attendances. Explore with Wandsworth CCG, opportunity to implement the PNS at St Georges NHS Trust
- **Addressing care pathways with significant patient flows:** Within ophthalmology, trauma and orthopaedics. One-stop diagnostic shops for cardiology; urology; gynaecology with onward referral protocols
- **Ophthalmology:** Develop and procure options for a community glaucoma pathway to provide local, assessment and treatment
- **Trauma and Orthopaedics:** Refine the orthopaedic pathway by commissioning additional musculoskeletal capacity within East and West Merton. Option to establish a LES for exercise, information and analgesia
- **Cardiology:** Review options for procuring a one stop shop diagnostic clinic in the community, to support primary care, with protocols for discharge to GPs and further investigation
- **Urology & Gynaecology:** Community urology and gynaecology, continue to utilise these services across all practices

Provider Impact:

Primary Care	• Engage practices in the review of clinical support needs in relation to clinical referral support system. Anticoagulation capacity to increase within individual GP practices and GP practice hubs to facilitate repatriation of patients out of hospital.
Community	• Increased resource for MSK/physiotherapy provision in Merton; establish satellite services in East/West Merton. Pelvic floor service needs to link with community continence service.

Acute	• Clinical efficiencies in outpatient attendance in the following specialties: Ophthalmology; • T&O; cardiology; urology; gynaecology; anticoagulation predominantly at St George's, St Helier and Kingston Hospitals. • Potential efficiencies in first referral rates to secondary care and diversion to community services, across key specialties.
Mental health	• N/A
Social care	• N/A
Medicines Management	• Increase in prescribing cost; address Low Molecular Weight Heparin prescribing profile in primary care.

Anticipated benefits/outcomes in relation to organisational goals/priorities

Right Services	• Development of more elective care closer to home will ensure patients gain access to well commissioned local services. MSK triage services will ensure patients receive early intervention; treatment and self-care advice.
Right Setting/ Right Time	• Ensure clear clinical thresholds of referral to services will ensure appropriate treatments in relation to need e.g. Primary Care; Enhanced services; Secondary care; Tertiary services. • Offering the right care and appropriate level of clinical intervention, so that people feel satisfied, confident and aware of the appropriate services to access in our local system.
Right Outcomes	• Improved patient pathway for PFC; Patient Navigation Project will reduce the need for patients to attend unnecessary hospital follow up appointments.
Transformation and productivity	• Development of clinical referral support will facilitate referral to the right service, in the right setting, at the right time with high quality clinical outcomes. • Patient navigation project will reduce follow up attendances. Optimisation of hospital 1st outpatient & f/u attendance. Improved pathways leading to reduction in service duplication; & consultant to consultant referrals.

Anticipated financial impact on provider SLAs (2013-14):

- Referral processes with clinical triage and support will result in the reduction of acute outpatient activity with a shift into primary and community care settings. This will predominantly impact St Georges, St Helier & Kingston Hospitals.

5. Children & Young People

MCCG is committed to commissioning the full range of comprehensive children's services required in Merton to meet the needs of children and young people locally, whilst also completing a systematic quality review with clinical leads of those services for on-going improvements in service quality, safety and value for money. This will be achieved by working closely with Public Health/Local Authority colleagues and partners, as part of arrangements within the Children's Trust, to ensure robust commissioning arrangements and establish a systematic process of review.

Summary of initiatives:

- **Safeguarding**

MCCG has a statutory obligation under "General duties applying to NHS or public bodies"[1] to meet Safeguarding duties as follows:

- Having regard to the need to safeguard and promote the welfare of children
- Following the requirements around employing members of staff
- Being a member of the Local Safeguarding Children Board(s)
- Currently a Designated Nurse for Child Protection for Merton has been identified for Merton CCG and the Designated Doctor for Child Protection is currently commissioned from Epsom and St Helier Trust.
- MCCG will review the Child Death Overview Process and draw on best practice models with the Local Authority.
- We will review the current delivery model for MASH from the perspective of health involvement and the specific roles required of CCGs, as being developed by NHS London.

- **Multi-Systemic Therapies (MST):** MST is a successful intense family and community therapies based alternative to care or custody for young people (11-17yrs) with conduct disorder and emotional problems. It focuses on improving parenting, increasing education and training, and tackling underlying health- mental health problems. MCCG will work with CAMHS provider to reshape current delivery to mainstream MST from April 2014.

- **Health Team in Special Schools:** Assess both current service provision and future service needs in line with recommendations of the JSNA and increasing population to ensure robust commissioning of child health services to include a range of therapies (Occupational Therapy, Physiotherapy, Speech & Language Therapy and Dietetics) and Special School Nursing.

- **Child and Adolescent Mental Health Services (CAMHS) including Tiers 1-4:** Work with the current provider to reconfigure Tier 2 and 3 CAMHS services as part of the sector wide CAMHS review, in consultation with the London Borough of Merton and other partners. Agree future commissioning model with SW London CCGs, incorporating sector wide expertise with provision focused on and driven by local need. Ensure clear pathways across CAMHS Tiers, particularly Tier 4, which is already commissioned on a SW London basis.

- **Complex Needs Services – For Children with very complex health needs:**
  Decommission acute paediatric services pending the outcomes of the 'Better Ser**v**ices Better Value' review:
  - Develop a pathway across community and acute settings to ensure seamless services for children with complex health needs.
  - Work with Sutton & Merton Community Services (SMCS) to ensure the Children's Outreach Team is 'fit for purpose' in preventing unnecessary hospital admission, reducing the need for independent and residential providers of discharge care and providing necessary support for those children and young people with additional and complex health needs, in the community.
  - Work with LBM colleagues to ensure that individual packages of care are commissioned through an integrated approach across health, education and social care to ensure they are appropriate and cost-effective.

[1] As part of our statutory responsibilities under the new constitution

- **Children's Occupational Therapy Services** have seen an increase in referrals over the last 3 years and MCCG will work with the Provider to review the service.

- **Local Authority/Public Health:** Services below will be commissioned by Public Health by 2013 and MCCG will review with Public Health the required segregation of responsibilities and duties;

- 'Looked after Children's Nurse' – review to clarify commissioning arrangements in line with the DoH proposals for statutory health assessments, which will be commissioned on a PbR basis.
- School Nursing – to be commissioned by Public health.

- **Health Commissioning Board:** Establish a process to disaggregate Health Visiting Service and the commissioning function.

Provider Impact

Primary Care	• Engage practices in the review of clinical support needs in relation to clinical referral support system. • Practices & GP practice hubs to facilitate repatriation of patients out of hospital.
Community	• Increased resource for MSK/physiotherapy provision in Merton; establish satellite services in East/West Merton.
Acute	• N/A
Mental health	• Possible reduction of activity within CAMHS Tier 3 services as a result of wider review
Social care	• N/A
Medicines Management	• Increase in prescribing cost; address Low Molecular Weight Heparin prescribing profile in primary care.

MCCG organisational goals – anticipated benefits/outcome

Right Services	• Children and young people can access community health services based on need as close to home as possible and within integrated settings of care i.e. Children's Centres, schools and other community settings
Right setting/ Right time	• Children and young people can access the right health service need in their community that is available at convenient times and settings of care that wrap around the busy lives of families.
Right Outcomes	• Children & Young people benefit from health promotion and prevention, as well as high quality services that offer the highest possible clinical outcomes.
Transformation and activity	• Reduction of referrals from acute hospitals to independent provision for children with complex health needs. Improved working together by all NHS and partner services to reduce duplication and offer integrated services.

6. Staying Healthy & Prevention

Work with partners to commission high quality health improvement services focused on prevention and target health inequalities. The staying healthy and prevention programme is underpinned by the Merton Health and Wellbeing Strategy (draft) and the Joint Strategic Needs Assessment.

Learning from 2012-13:

The Staying Healthy and Prevention programme is underpinned by core priority themes set out in the Health and Wellbeing Strategy, and incorporates priorities that will be led by Merton Council under the transfer of Public Health responsibilities from April 2013.

Summary of initiatives:

Giving Every Child a Healthy Start

- Ensure we provide access to comprehensive antenatal care to maximise wellbeing during pregnancy and delivery of a healthy baby e.g. by ensuring that over 90% of women see a health professional within the first 13 weeks of pregnancy
- Ensure effective postnatal follow up, including the identification of postnatal depression.
- Ensure breastfeeding support to increase initiation of breastfeeding and continuation at 6-8 weeks post delivery
- Support delivery of childhood immunization programme in order to meet the ideal 95% coverage
- Ensure comprehensive Health Visiting services include delivery of the complete 'Healthy Child Programme', including the age 2 health visitor assessments, to ensure the earliest identification of health and wellbeing issues
- Ensure that Primary Care plays an active role in the identification, referral and support for weight management for children and families
- With partners, review and re-commission children and young people's weight management programmers to support the National Child Measurement Programme
- Support the London Borough of Merton to commission effective School Nurse Services
- Ensure that Primary Care plays an active role in the identification, referral and support for children and young people with mental health issues, and timely access to CAMHS
- Ensure that Primary care plays an active role in the identification, referral and support for children and young people at risk of risky behaviours, including sexual health, substance misuse and smoking, signposting to appropriate services
- With partners, explore the potential of commissioning integrated substance misuse, sexual health and stop smoking services for young people by October 2013

Supporting People to Improve Their Health and Wellbeing

- Commission systematic training and support to ensure that health professionals are skilled to promote health and 'make every contact count' e.g. explore the use of e-learning packages
- Increase the number of residents receiving an NHS Health Check target 20%
- Contribute primary care expertise and patient care that facilitates effective local authority commissioned integrated health improvement services that help to:
    - Reduce overweight and obesity in the Merton population and reduce demand for bariatric surgery
    - Increase smoking quit rates (4 week quit rates)
    - Support smokers from target groups to quit smoking (routine and manual workers, BAME groups, young people and people with mental health problems)
    - Reduce risky drinking behaviour (Increase participation in physical activity (increasing numbers of over 16 years who participate in 150 minutes of physical activity per week)
    - Increase the proportion of the BAME population that access healthy living services

- Increase the proportion of people with mild to moderate mental health problems accessing healthy living services to address their physical health needs

Increase Healthy Weight and Physical Activity

- Review and commission effective adult weight management services
- Extend opportunities for physical activity and active travel
- Support workplaces to promote healthy food choices and active travel through the public health responsibility deal

Stop Smoking

- Further education initiatives around smoking cessation and tobacco control to key frontline staff, e.g. midwives
- Build smoking cessation into care pathways and support patients to stop smoking before planned surgery

Promote Sensible Drinking, Reduce Alcohol Related Harm and Harm from Drug Misuse

- Work with partners to promote a culture of sensible drinking and ensure that alcohol related prevention and treatment services are cost-effective and targeted
- Reduce substance dependency, improve health and reduce inequalities as a result of substance misuse
- In April 2013 re the local adult substance misuse treatment service, we will support the re-commissioning of this and identify further opportunities to contribute to this agenda

Improve Sexual Health and Access to Services

- Commissioning priorities are to address the need to reduce the transmission and rate of undiagnosed HIV and sexually transmitted infections
- Improve access to sexual and reproductive health services, and increase the capacity of Primary Care to deliver these services
- Ensure timely access to comprehensive Termination of Pregnancy services with effective post termination contraception to ensure a reduction in repeat terminations
- We will work with the London Borough of Merton in partnership to ensure that commissioned services:
  - Implement HIV testing, initially in new medical admissions at St Helier Hospital
  - Contraceptive and Sexual Health (CASH) services to deliver HIV testing within their services
  - Review the opportunities to increase access and use to long acting reversible contraception (LARC)
  - Improve quality indicators for chlamydia treatment and partner management to reflect national percentages

Provider Impact

Primary Care	• Greater role for Primary Care in identification, referral and support for health improvement and prevention, resulting in improved outcomes for service users and reducing health inequalities.
Community	• Greater role in identification for health improvement • Resources redirected to provide more early intervention and preventative services in community settings. • Longer term care provision to be enhanced to ensure more activity is delivered within community settings
Acute	• Long-term reduction of activity commissioned from acute health providers across a range of areas relating to; cardiovascular; disease and stroke, cancers and diabetes. Cost reductions including in relation to bariatric surgery and costs associated with treating obese patients and post-operative care of smokers.

Mental health	• It is not clear if there will be a direct impact from Staying Healthy and prevention programmers on mental health services.
Social care	• Continue working with the Local Authority as a lead for Public Health from April 2013.
Medicines Management	• Improved access to preventative services may result in reduced prescribing levels in the community in the long term.

Anticipated benefits/outcomes in relation to organisational goals/priorities

Right Services	• Improved primary care and quality, accessible health improvement services.
Right Setting/ Right Time	• Improved access to health improvement services and increased capacity in primary and community settings
Right Outcomes	• Reduce the number of people with long term health conditions • Reduction in health inequalities • Improved quality of life
Transformation and productivity	• Ongoing development of health improvement services co-produced with the communities and provided in accessible community and primary care settings.

Anticipated financial impact on provider SLAs (2013-14):

Primary Care:	• Increased demand for Primary Care in-hours and out-of-hours services as people access more of IAPT services within primary care settings.
Community:	• Increased demand for care coordination and/or case management.
Acute/Secondary care	• A refocus on mental health interventions at an earlier stage of the care pathway will help support a reduction in crisis admissions, access to tertiary care and a reduction in LoS within inpatient services.

7. Maternity & Newborn

Commission the following initiatives in partnership with Public Health, fellow CCGs and the national Commissioning Board as appropriate:

Improve quality and productivity within maternity and newborn services via the following actions:

- Focus on continuing to reduce the level of smoking among pregnant women
- Promote breastfeeding
- Review current service use to ensure only clinically necessary Caesarean sections are carried out
- Reduce unnecessary antenatal appointments via early clinical intervention where appropriate
- Improving access to services – ethnicity monitoring

Summary of Initiatives

- Commission community midwifery services to work in Children's Centres, including a specific clinic for pregnant teenagers
- Working towards UNICEF Baby Friendly Initiative in recognition of improved support for breast feeding and appoint a breastfeeding and infant nutrition advisor
- Joint working between Health Visitors and Midwives to improve breastfeeding continuity at 6-weeks. Work with acute providers to develop a COQUINA to enable staffing ratios to be increased over time
- Ensure 'Live Well Service' available in Merton for all adults over 18 years to improve their lifestyle including advice on weight loss (pre-conceptually)
- Focusing on LOS (Length of Stay) where clinically appropriate ref C sections

8. End of Life Care

Building on the success of EoLC, Merton CCG will continue to commission services to achieve the following priorities:

Key Priorities:

- Review and evaluate service provision and initiatives of the EoLC programme
- Develop a programme of investment and service development
- Ensure that 40% of Practices are signed-up to EoLC LES
- Ensure that at least 0.4% of the Merton population is recorded on a Practice Palliative Care Register enabling better access to services and better integration of care services for EoLC
- At least 0.2% of the total Merton population is recorded on the Co-ordinate My Care (CMC) system
- Ensure that all Merton Nursing Homes are working towards the implementation of CMC.
- Ensure that at least 75% of patients on the CMC register, who express a preference for their place of death, are enabled to die in their preferred place. Build on the successful model of the current EoLC network to identify areas for improvement
- Maintain and develop the 'Hospice at Home' service to enable an increase in patients dying at their preferred place of death
- All patients to be offered a choice of a place of care and death, where possible.
- Appropriate support services are available for both the dying person, their family, informal carers and friends.
- End of life services based on current best practice models.
- Ensure, via MCCG commissioning processes, that appropriate EOLC training is developed and delivered.
- Review cost-effective use of existing resources.

Provider Impact

Primary Care	• An increase in service provision within primary care services to allow patients the choice of dying at home, or in residential/nursing home
Community	• Ensuring the right level of clinical skill-mix and training within the community to enable patients to achieve their preferred place of care • Optimum community provision with integrated working with primary care to allow patients the choice of dying at home.

Acute	• Optimum provision of the acute based schemes to enable discharge back into the patient's home; 'Home from Home' at the Royal Marsden Hospital FT, as well as an increase in the 'Rapid Response Team' scheme based at St George's Hospital.
Mental Health	• N/A
Social care	• Potential impact on the increased need/use of equipment to be monitored via the multi-agency Integrated Care & Equipment Services group.
Medicines Management	• Increased levels of prescribing and potential shift of costs into primary/community care.

Anticipated benefits/outcomes in relation to organisational goals/priorities

Right Services	• Appropriate support services for both the patient, their family, informal carers and friends • Build on the successful model of the current EOLC network to identify areas for improvement • Maintain and develop the 'Hospice at Home' service to enable an increase in patients dying at their preferred place of death
Right Setting/ Right Time	• Improved access and increased capacity in primary and community care settings • Patients should be offered a choice of place for care and death, which enables their preferred choice to be realised.
Right Outcomes	• 75% of patients on the CMC register who express a preference for their place of death, are enabled to die in their preferred place • Reduction in the number of people presenting in crisis to mental health services
Transformation and activity	• CMC target; greater use of CMC across multi-disciplinary teams to enable the right outcomes

ABBREVIATIONS

AQP	Any Qualified Provider
A&E	Accident and Emergency
BSBV	Better Services Better Value
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CMHT	Community Mental Health Team
CQUIN	Commissioning for Quality and Innovation
CSP	Commissioning Strategy Plan
CMC	Co-ordinate My Care
DES	Directed Enhanced Services
DoH	Department of Health
EoLC	End of Life Care
ENT	Ear, Nose and Throat
ESD	Early Supported Discharge
GPwSI	GPs with Specialist Interest
Gynae	Gynaecology Services
HASU	Hyper Acute Stroke Unit
H&WB	Health and Wellbeing Board
IAPT	Increased Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAS	London Ambulance Service
LBM	London Borough of Merton
LCP	London Cancer Programme
LES	Local Enhanced Service
MCCG	Merton Clinical Commissioning Group
NHS	National Health Service
OPMH	Older People's Mental Health
PbR	Payment by Results (a DoH system of payment for clinical activity rendered within an acute contract for services)
Physio	Physiotherapy Services
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality Outcomes Framework
SPA	Single Point of Access
St George's	St George's Healthcare Trust in South West London
VfM	Value for Money