Thinking Differently

NHS
Dudley
Clinical Commissioning Group

Commissioning Intentions 2017/18 and 2018/19

1.0 Background

These commissioning intentions are designed to build upon and implement the strategic objectives set out in our 5 year strategic plan for 2014/19:-

- Efficient and Effective Care
- Healthy Life Expectancy
- Mutual Approach to Achieving the Best Possible Outcomes
- High Quality Care for All

Since the development of these strategic objectives, our participation in the Five Year Forward View New Models of Care Programme, as a national Vanguard site, provided an added impetus and opportunity to secure their delivery. This was reflected in the commissioning intentions we published last year for 2016/17 and 2017/18. We now intend to build on these in the context of the NHS Operational Planning and Contracting Guidance for 2017/19.

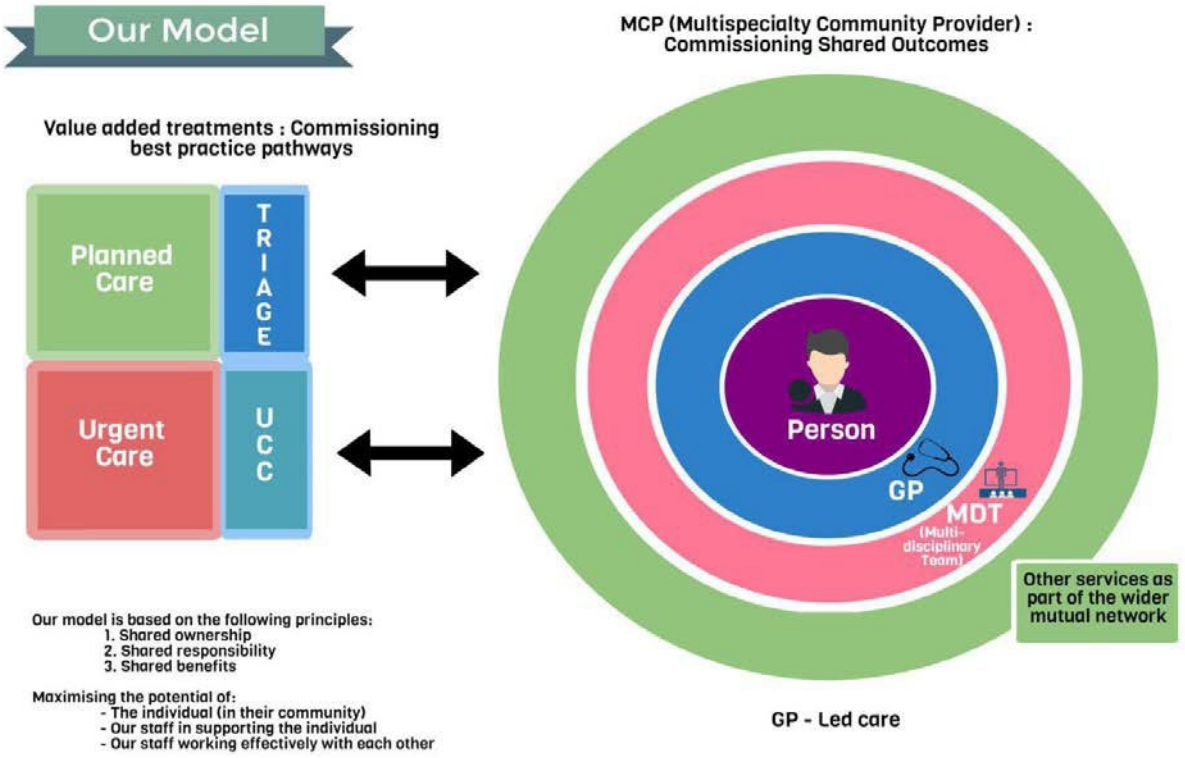
Central to our plans is our new model of care – the Multi-Specialty Provider (MCP). This is designed to deliver population health and wellbeing based on the principles of shared ownership, shared responsibility and shared benefits, maximising the potential of:-

- individual patients and citizens;
- our staff in supporting those individuals;
- our staff working effectively with each other.

Our ambition is enabled by:-

- better communication with patients and between staff;
- improved access to different types of consultation and diagnostics in the community;
- continuity of care in supporting the management of peoples long term conditions;
- effective co-ordination of care for the frail elderly and those with the most complex conditions.

To respond to this, the focus of our model of care builds on a joined up network of GP-led, community-based Multi-Disciplinary Teams (MDTs) which enable staff from health, social care and the voluntary sector to work better together in the MCP. This is also underpinned by a complementary process of developing standardised best practice pathways of care. Through this we will ensure that all services provided outside of the MCP are commissioned in a way which incentivises optimum outcomes for the patient, maximises efficiency and enables effective communication with the GP.



Our main partners – The Dudley Group NHS Foundation Trust (DGFT), Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT), Black Country Partnership NHS Foundation Trust (BCPFT), Dudley Metropolitan Borough Council (DMBC) and Dudley Council for Voluntary Services (DCVS) – will be familiar with the model and we have come together under our Partnership Board arrangements to implement it. Through this arrangement we have agreed to manage the risks together and find new ways of thinking and doing to make the difference that we have not been able to make to date.

Following a period of public consultation, the CCG Board has agreed the scope of services to be provided, the outcomes to be delivered and the characteristics of the MCP organisation. The latest versions of these documents can be accessed at http://www.dudleyccg.nhs.uk/mcpconsult/

There are three elements to the model based upon the fundamental Principle of supporting population-based health and wellbeing. This starts with the patient registered with their GP - the main co-ordinator of their care. This is delivered through a mutual network of care, best exemplified by the work of a practice based Multi-Disciplinary Team (MDT), linked to a series of other community-based services. This, in effect, is the MCP based on the principles of shared ownership, shared responsibility & shared benefits.

The mutual network of care, to be delivered by the MCP, will be commissioned around the following themes and outcomes:-

- better **communication** with patients and between staff;
- improved **access** to different types of consultation and diagnostics in the community;
- **continuity** of care in supporting the management of peoples' long term conditions;
- effective **coordination** of care for the frail elderly and those with the most complex conditions.

We will support people to remain at home wherever possible by developing evidence based best practice pathways of care. This is the second element of the model. We will reduce variation, so that all services are commissioned and delivered in a way which incentivises optimum outcomes for the patient, shares risk, makes the best of the resources we have available; and enables effective communication between all stakeholders. To enable the delivery of pathways for value-added treatments in relation to both planned and urgent care, we intend to move away from Payment by Results (PbR) tariffs to a payment that reflects best practice.

The final element is a primary medical services system, which we recommissioned from 1 April 2016 through a new outcomes based contractual framework, again reflecting the themes of access, continuity and co-ordination.

Our objective has always been to achieve these intentions, wherever possible through collaboration with our providers and significant progress has already been made in implementing elements of the new care model regardless of how services have been contracted for previously.

Our intention is to now build on this development and to fully contract for The model of care through a procurement process. Subject to the outcome of The national Joint Assurance Process, we will commence the procurement in Autumn 2016, with a view to having the MCP operational by 1 April 2018.

2.0 Context and Environment

We face a significant and collective challenge to achieve financial balance across the system. The planning and contracting timetable requires a pragmatic means of achieving contract sign off by the due date, whilst dealing with all the relevant technicalities. An immediate collective view is required of this challenge and the range of initiatives we can share to meet our respective but linked QIPP and CIP targets, whilst taking account of the factors set out below.

Therefore, we will be making the appropriate arrangements for key stakeholders in the Dudley health and care economy to meet as early as possible to develop an open, transparent, collective financial plan that moves us away from the traditional transactional process.

3.0 National Planning Requirements "Must Dos"

In meeting national planning requirements and "must dos". We intend to approach these under 3 main blocks of activity relating to:-

- Planned Care
- Urgent and Emergency Care
- Mental Health

We will identify the resource implications of meeting all national planning requirements relating to these blocks within an overall cost envelope agreed with our providers. We then propose to identify, through a clinically led process, those initiatives we can implement jointly to deliver the cost savings the system requires in relation to these blocks.

This process will be informed by the latest available tools and guidance including:-

- Right Care
- Demand Management Good Practice Guide
- NICE Guidance on delayed transfers of care

The starting point for this process will be the meeting referred to at 2.0 above. Followed by provider specific sessions during the course of October and November.

4.0 Key Enabling Partnerships and Programmes of work

We have established some key partnerships and ways of working to enable us to implement the model of care. We will expect the full cooperation of our providers in each of these areas of work.

Integration of health and social care

The heart of our model of care aligns social care and health together with the voluntary sector. Firstly, this is right for our population because very often they will present with both health and social care needs, so to separate services artificially ignores the needs of our population. Secondly, the challenges faced by social care are such that we believe the only long-term solution for sustainable delivery is to fully integrate health and social care so that the challenges are fully shared. We will work with our Council partners to procure a MCP that will deliver a number of public health and adult social care services as a means of fully integrating the provision of health and social care.

Empowering 'teams without walls'

Central to our way of working is an empowerment methodology which creates the right framework and tools for teams (initially our community MDTs) to work together to solve the problems and challenges in meeting the needs of their population. This builds capability in teams and gives flexibility to different teams to respond to different needs and challenges with their specific population.

Part of our empowerment methodology includes the implementation of a cross- system organisational development programme which utilises staff from within our existing providers to support the development of the teams. Therefore, we will expect full collaboration from all providers to contribute their staff time to participate in this OD programme.

For 2016/17 we already have plans in place with providers for the further development of these teams and their connection to the wider network of care, largely facilitated through the CQUIN process. We will expect our providers to fulfill their existing CQUIN obligations during the remainder of 2016/17, develop and consolidate this work during 2017/18 prior to MCP mobilisation.

Creating a self-improving system

A key aspect to Dudley CCG's plans for the MCP is the commitment to a robust evaluation of impact. Evaluation is an active component of change management, ideally achieving a balance of meaningful practical application and methodological rigour. For the Vanguards, dealing with high levels of complexity and uncertainty, theory-based evaluation offers a robust approach to measuring impact. The logic model is a key tool to support this approach. The logic model is a graphic representation of the relationship between programme assets, activities and intended outcomes. Currently the required outcomes are being assessed along with the degree of change and impact for service users. Thereafter, the evaluation development will be focused on working backwards from these outcomes through to the connected activities and resources required.

The starting point for our approach to evaluation is to see it as a fundamental part of a self-improving system. One of the characteristics of such a system is that it seeks and acts upon evidence; that it adopts a reflexive and healthily self- critical approach; and that there is a feedback loop of producing, interpreting and acting upon information. This understanding runs throughout the proposed design of our evaluation. The evaluation will therefore be:-

- highly formative - we will use the evaluation on an ongoing basis; there will be short feedback loops between evidence gathering and reporting; and will base the design and ongoing operation of our model upon the best available and most current evidence; here we will benefit from the Strategy Unit's evidence review capability to create a 'living review', which would be updated frequently and used by us as a key design input;
- facilitative and empowering - in order for evaluation to act as one of the feedback loops in our system, several conditions must be present. On the 'supply side', evaluative evidence must be available at the right time and be of the right type; and, on the 'demand side', there must be sufficient capability within the system to interpret and act upon it. Therefore, our evaluation would work closely with MDTs to help define, capture and report metrics that are of use to these teams; MDTs will also be given training in the use / interpretation of evidence as part of our empowerment methodology.

The evaluation will also examine different levels of the system, gathering evidence and feeding back insights:-

- at the micro level – looking at interactions between clinician and patient. For example, this might mean asking more questions about the causes of attendance at primary care – such as social isolation – driven by the knowledge that there are now services to help address such causes. The focus here would be on outcomes for patients and individual staff members;
- at the meso level – looking at the operation of the MDTs. This would entail examining the operation of the MDT model across localities, tracing their development from representatives of individual organisations to genuine whole team working. The focus here would be on more efficient and effective ways of working and the evaluation would play a highly developmental role - extracting and transferring elements of effective practice across localities;
- at the macro level – looking at the Dudley health and social care economy.

Here the evaluation would examine the role of the Vanguard in creating a sustainable and self-improving system. This would entail gathering evidence and insights from different partner agencies – the local authority, the voluntary and community sector, the acute and mental health providers – to trace changes at this level. One of the key aspects of change tested at this level would be the increasing adoption of a 'system perspective', as opposed to an individual organisational perspective.

Effective IT systems and support

It is an essential component and enabling factor in the delivery of our care model. So we have commissioned Alscient Ltd to provide us with external expertise to oversee improvements in our IT infrastructure. There are two main components to this work:-

- ensuring future-fit-for-purpose IT support - the necessary managed IT support services that will be needed to first-and-foremost provide an effective and efficient service to General Practice;
- developing an integrated IT solution. An essential component of empowering staff to work effectively together is to ensure that they are working together accessing a single consistent patient view. It is therefore our intention to ensure that all services that form part of the MCP are working in this way through inter operable systems. This will also facilitate the ability to meet the new national requirements on providing patients with access to their records.

Dudley Partnership Board and external expertise through the national New Care Models Programme.

Our main providers, together with Dudley MBC and Dudley CVS are working with us, through the newly formed Partnership Board, to collaborate on the development of the new model of care. We will continue to use the Partnership Board as the main forum for this collaboration as the model of care develops.

Through the national New Care Models Programme we will be accessing external support to assist in the implementation and contracting for our new model of care. This will include legal and procurement advice on the process for implementing the new contracts to enable the new model of care;

- engagement with regulators through the Joint Assurance process; sharing and learning of best practice for rapid adoption within our system where appropriate; workforce development to enable the new care model.

5.0 Changes in the distribution of resources and the value of services

We have already shared with our main providers the anticipated financial consequences of implementing the new care model. On the basis of the intentions described we anticipate the balance of investment at a time of reducing resources to be:-

- planned care – reduction as waste and variation are eliminated;
- urgent care – reduction due to impact of specific measures;
- continuity and co-ordination elements – increased on the basis of the use of new technology and enhanced team working to contain demand for other services including urgent care;
- primary care – increased to create the scale the model of care requires.

The process that we undertake in the next three months and the meeting referred to at 2.0 above will be designed to achieve as much collaboration as possible on understanding the scale of change required.

Determining the value of services and efficiency requirements

In previous years' commissioning intentions we invited providers to identify their view of the value of the services that they provide (for example - what outcomes is a service designed to achieve, how is this measured, and is it value for money). The response to this invitation was disappointingly very limited and the reporting on the value of services is very variable. However, it is essential that we have a shared view with our providers about the contribution that each service makes to the new model of care.

6.0 First Component of the Model of Care: Primary Care at the heart of the MCP

General Practice is at the heart of the model – it starts with the patient registered with the practice.

A New Contractual Framework

We intend to use our delegated responsibilities for commissioning primary medical services to full effect, continuing with the implementation of our long term conditions framework:-

a) Access

- enabling resilience in primary care is critical through the CCG's primary care strategy and development programme;
- supporting practices to work in partnership together where appropriate (for example: in providing urgent advice and guidance to local paramedic teams);
- working with practices to meet the requirements to enable full access to records for all patients across the system;
- creating a new "back office" function and eliminating unnecessary transaction costs to support efficiency improvement in primary care;
- standardising referral protocols, triage and discharge information to improve efficiency of communication (both ways) between primary and secondary care;
- ensuring all practices can utilise the full range of options for providing access to their patients (eg: online, telephone appointments, etc…);
- implementation of our estate strategy to support enhanced primary and community care capacity and capability.

b) Continuity

- an annual assessment of all patients with long term conditions;
- a named care co-ordinator;
- joint development of care plans with the patient;
- condition specific outcome targets - many shared with secondary care;
- the use of consistent templates through the EMIS system to support this.

c) Coordination

- an annual enhanced assessment of the frail elderly;
- monthly MDT meetings carried out to a consistent format;
- providing professional advice and guidance to the MDTs;
- unplanned admissions – replication of the existing Directed Enhanced Service;
- support for patients with dementia and palliative/ end of life needs;
- systematic management of patients in care homes;
- systematic management of repeat prescribing.

Systematic actions in primary care and the rest of the system will place an emphasis on upstream preventative interventions.

Shared Responsibility for Shared Outcomes

We will reflect this principle in the way this contract and that for services within the rest of the care model are framed. There will be explicit agreements between the GPs and clinicians elsewhere in the system about their respective responsibilities for managing practices' patient population in relation to specific service areas. For example:-

- each MDT will share responsibility for the outcomes for their population of patients;
- for each long-term condition, where continuity of care may take place across more than one service provider, there will be a shared objective between that provider and general practice.

7.0 The Multi-Specialty Community Provider (MCP)

As previously stated, we intend to commence the procurement process for the MCP later this year with a view to contract mobilsation from 1 April 2018. The fundamental operating model of the MCP is the Multi-Disciplinary Team (MDT) to deliver on the co- ordination of care. Care co-ordination will then be further enhanced at scale by the delivery of a new frail elderly pathway. In addition there are a range of condition - specific services which will link to GPs to provide continuity of care; and a range of services which will be on a community access basis.

Commissioning the practice MDT

The existing essential elements of the MDT are:-

- GP – primarily commissioned as described earlier;
- community nurse;
- mental health professional;
- social care professional;
- access to a practice pharmacist;
- voluntary sector link worker.

Our empowerment methodology will give scope to the MDTs to determine for themselves how they meet the required objectives for their population. This needs to include the capability for teams to flex or change the balance of skills within their teams, to reflect the particular needs of their population.

Whilst much of the focus of our work will be on using the care model to manage the needs of an increasingly frail elderly population, we recognise, in conjunction with our partners, the opportunities that exist to use this model to deliver more integrated children's services, particularly for those children with more complex needs and those with emotional health and wellbeing needs.

Whilst for adults, the practice is a key locus of activity, for children with both complex and less complex needs the school has a significant role as well. The intention will be to replicate integrated working across physical health, mental health, children's social care and education services – all on the basis of a team with shared responsibility, for a shared population and shared objectives.

Commissioning the mutual network of care - access

A number of services that are part of the wider mutual network of care within the MCP are predominantly value-added treatments. We will be giving further consideration as to whether some of these services should be opened up to the public so that they can access the service directly without having to be referred by their GP – and therefore reduce the burden of activity on general practice. Initially we intend to do this for primary mental health care, counselling and physiotherapy.

Commissioning the mutual network of care - continuity

We intend to extend the 'team without walls' concept that has been developed with the MDTs, to incorporate a similar team approach across primary and secondary care, taking shared responsibility for shared objectives on specific long-term conditions and mental illness.

Our intention is to transform the services so that:-

- the majority of care is delivered in the community;
- each patient is clear who is leading on the continuity of their care (through, where required, shared care arrangements and clear records linked back to the GP practice);
- there are clear outcome objectives for each service and those objectives are shared across all the contributors to that service.

Commissioning the mutual network of care - coordination

We have described above how we will commission primary care to be at the heart of the model with the GP as the overall co-ordinator of care. In addition, we have described how we will commission the MDT.

We will extend further the concept of care-coordination to include all services delivered at scale in support of the objectives for the MDTs. This will include all components of the frail elderly pathway such as:-

- geriatricians and medical care for the elderly;
- the further alignment of social care services;
- intermediate care services and discharge support services;
- assessment services;
- continuing healthcare and nursing home care;
- prevention services such as falls prevention.

The frail elderly pathway will start and finish with the MDT as the locus of control for complex care management with shared outcomes relating to:-

- secondary care admission avoidance;
- care home admission avoidance;
- supporting reablement;

- enabling improved end-of-life planning and compliance;
- reducing social isolation.

From 1 April 2017, the frail elderly pathway will be commissioned as a single service that supports the MDT. The MDT will control access to intermediate care in conjunction with the intermediate care assessors and be responsible for ensuring assessments for NHS Continuing Healthcare take place. We will review the intermediate care pathway and associated re-ablement services with a view to ensuring there is appropriate investment across the health and care system.

The role of care homes in the system is crucial. We intend, in conjunction with our local authority partners, to ensure that appropriate contractual incentives are in place and supporting services are available to support best practice in relation to:-

- avoiding unnecessary 999 calls and emergency admissions;
- managing patients appropriately at the end of life;
- facilitating effective discharges from secondary care.

Integrated Referral and Information System

We want to create a local public service for Dudley people that improves their ease of access and enables appropriate advice and guidance to connect up with the ability to book appointments. From 1 April 2017, we intend to bring together a range of services into a single integrated approach across health and social care which will give the public just one point of contact to access relevant and inter-connected services. This builds on some existing arrangements and will include:-

- NHS 111;
- telehealth and telecare;
- online services;
- social care emergency duty services;
- those access services within the MCP which are bookable;
- community mental health hub;
- GP out-of-hours.

Patients and professionals will use a single number to use the centre. The centre will also actively manage “call flow” and use “down time” to make proactive calls to cohorts of patients – e.g. reminding them about appointments, medicine reviews, vaccinations or alerts from their telecare/health devices. The option for any primary medical service provider to use this resource for appointments and telephone advice will also be incorporated.

8.0 Effective Care Pathways

We intend to commission effective and efficient care pathways that enable practices to manage their patients appropriately. This will be based upon:-

- Introducing appropriate triage to streamline processes and improve efficiency;
- Implementing best practice pathways to reduce the total number of pathways and eliminate unwarranted variation within pathways;
- locating out-patient services, where appropriate, in more local community settings.

For all patients referrals from general practice will initially be for "advice and guidance" only. Each Provider who delivers services under an NHS Standard Contract must offer clinical advice and guidance to GPs on potential referrals through the NHS E-Referral Service, whether this leads to a referral being made or not.

GPs should use all reasonable endeavours to ensure that all referrals are made through the NHS E-Referral Service. Providers have a contractual obligation to include Advice and Guidance for all services and specialties on the NHS E-Referral Service.

Furthermore, each provider must make the e-referral information available to prospective, patients through the NHS Choices Website. It must also use NHS Choices to promote awareness of the services among the communities it serves, ensuring the information is fully compliant with national policy.

Advice, guidance and triage

The current system of referral is hugely problematic and can often create extra work for both GPs and secondary care. We will therefore work with GPs and consultants to develop an effective triage arrangement for all elective services. This will be designed to streamline working practices and ensure consistency and efficiency of referral; as well as consistency and efficiency of guidance or discharge information back to practices.

Best practice pathways

Work has already commenced, under the oversight of the Clinical Strategy Board, to develop a series of efficient elective pathways focusing on the following specialties:-

- Ophthalmology
- MSK
- Urology
- ENT
- More recently IAPT and EIS

A key aspect of the unwarranted variation is the significant difference in levels of follow-up activity. Our initial analysis indicates the potential to reduce numbers of follow-ups in elective specialties as follows:-

- Ophthalmology – 12%
- Rheumatology - 12%
- Urology – 10%
- ENT – 6%

We expect to agree a significant reduction in the levels of follow-up activity for contracts, followed by a move away from PbR tariffs with contracts set on the basis of the optimum pathway.

Planned care interventions will be supported by appropriate diagnostic services in the community wherever possible.

Outcome objectives for these and other "access" services will be based upon both timeliness of response and upon the expected value-added outcome improvements that the service is designed to achieve. If value-added outcome measures cannot be demonstrated for any service(s) then we will establish a review process with a view to decommissioning the service(s) by April 2017 following public consultation.

9.0 Patient Experience

We expect providers to be responsive to complaints and patient feedback, dealing with them in an open, rapid and fair manner. We will roll out the patient experience app – Mi Experience - to all commissioned services across Dudley to enable people to give real time feedback.

We expect there to be a culture of information sharing about the experience of patients in order that patients, carers and the public can have confidence in the services that we commission.

It is our intention to encourage the development of mature relationships between partners and providers based on integrity, openness and transparency. We therefore expect there to be an open culture of information sharing which uses patient experience to build a more detailed picture of an individual's experience at varying points of their care. This will see us moving from the comprehensive and rich picture we have of all services to focus on a select number of pathways to track an individual's experience. This change will enable us to measure individuals' experiences and link them back to their own journey.

We will explore ways of measuring experience along a whole pathway of care and introduce new patient reported outcome measures and personal goals to ensure we are measuring services in a meaningful way. We will build a network of Young Health Champions who will play a pivotal role in bridging the gap between organisations and the needs of young people accessing services in the borough.

10.0 Commissioning for Quality and Innovation (CQUIN)

The Five Year Forward View and our participation in the Vanguard Programme, sets out the vision for transformational change to improve outcomes, eliminate waste and reduce cost. A key element of our work will be to align incentives with the reform of payment approaches and contracts.

We will work with partners and the system to ensure that future incentive schemes are designed to help drive the changes required.

We intend to procure an integrated safeguarding model for adults and children to be delivered by the MCP. This will be based on strong integration across multidisciplinary and multiagency teams (co located where possible) working together for the protection of children and adults across the borough. The approach will build on the existing knowledge and expertise of the staff while increasing the ease of

communication and collaboration to protect vulnerable members of the community. By working together more closely, we will increase the effectiveness of a co-ordinated safeguarding response, alongside supporting greater service efficiency and resilience.

We will develop a new approach to the management of Clinical Quality Review Meetings with our providers. These will take a systems wide approach to quality and safety based around key system level themes.

11.0 Communications

All patient level clinical communications from providers (excluding discharge and transfer from care correspondence which shall remain in accordance with the requirements of the NHS Standard Contract Service Condition 11) shall be accurate and be delivered to the registered General Practice by the 2nd operational day post patient contact date. It is the CCG's intention to audit the threshold of achievement at each provider through entry to a quality requirement threshold within the local quality requirement section of the particulars for 2016/17 NHS Standard Contracts.

12.0 Contract Type and Tariff

Contracts will need to be constructed on the basis of creating the appropriate degree of stability to support the move to the procurement of a Multi-Specialty Community Provider (MCP), whilst creating the appropriate conditions to commission those planned and urgent care services that will not be within the scope of MCP services.