Commissioning Plan Refresh
Change programmes and Control programmes

2016 – 2017
### NHS Warrington CCG
#### Five Year Forward View: 2015/16 Achievement against Plan

<table>
<thead>
<tr>
<th>Focus on prevention and CCG partnership working with LA/ Public Health; Obesity/ smoking/ alcohol/ other risk factors</th>
<th>✓ We’ve strengthened our partnership with Warrington Borough Council and Public Health colleagues</th>
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<tbody>
<tr>
<td>Development of Multi-specialty Community Providers</td>
<td>✓ We developed new models of provision through our partners in the new Community Interest Company (Warrington Health Plus)</td>
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<tr>
<td>Integration opportunities within Health and Social Care Economy</td>
<td>✓ The Better Care Fund has achieved 6.4% reduction in unplanned admissions</td>
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<td>Implement primary care co-commissioning as joint commissioners</td>
<td>✓ The CCG has appointed a lead commissioner for Primary Care and is working in collaboration with Halton CCG</td>
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<tr>
<td>New models of primary care provision</td>
<td>✓ Through the creation of Warrington Health Plus and working with our Community provider we have piloted Extended Access, Cluster Development, and enhanced Care Home Support</td>
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<tr>
<td>Dedicated resource delivered Winterbourne View action plan 2014/15. All cases allocated to Continuing Treatment Review.</td>
<td>✓ The post continues to work alongside our Providers to ensure patients are cared for in the appropriate setting to meet their needs.</td>
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<tr>
<td>Referral Gateway</td>
<td>✓ The Warrington Referral Assistance Gateway (WRAG) is implemented in all 26 GP practices and this will ensure an increase in relevant elective referrals generated from Warrington GPs are e-Referrals</td>
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<tr>
<td>Intermediate Care</td>
<td>✓ A new alliance contract for Integrated Out of Hospital Care has been developed with partners and will go live for the 2016/17 financial year</td>
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<tr>
<td>Sub Acute Services</td>
<td>✓ Short Term Assessment &amp; Rehabilitation pathways have been introduced to support patient flow</td>
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<tr>
<td>Psychiatric Liaison</td>
<td>✓ Liaison Psychiatry has been implemented in our main Acute provider</td>
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<tr>
<td>Ambulatory Emergency Care</td>
<td>✓ AEC pathways have been developed and are being introduced into our 2016/17 contracts</td>
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### NHS Warrington CCG
#### Five Year Forward View, the nine ‘must dos’:

| Develop a high quality Sustainability and Transformation Plan (STP) | Warrington CCG is a member of the Cheshire & Merseyside STP footprint to enable the spread of new care models. The Local Delivery System is constituted of Halton, St Helens, Knowsley, Southport and Formby CCGs along with NHS Warrington CCG.  

The CCG is an active partner in local Vanguards including the Cheshire & Merseyside Women’s & Children’s services partnership and The Neuro Network (The Walton Centre).  

We have developed service specifications and are working with our GP Practices and partners in the community to deliver new models of care which most closely align with Multi Speciality Community Provider models.  

The CCG is committed to working with partners to test new payment approaches and risk share arrangements including a shared health economy control total. |

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NHS Warrington CCG  
Five Year Forward View, the nine ‘must dos’:

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<tr>
<th>Return the system to aggregate financial balance</th>
<th>We are in the first wave of the Right Care programme. Our three areas for outcomes and efficiency have been identified and used to inform activity planning assumption for 2016/17 contracts. Details can be seen on slides 32 to 34.</th>
</tr>
</thead>
</table>
| Strengthening Primary Care services              | The CCG will introduce new Local Enhanced Services for Primary Care known as “The Warrington Brand” which will be at the forefront of innovative practice.  
These enhanced services will address issues identified with quality, sustainability and patient experience of directly accessed out of hospital services.  
In addition to GP OOHs we will continue to offer evening and weekend extended access to General Practice. |
| **Redesigning Urgent and Emergency Care services** | The CCG is working with Primary Care services and NHS 111 to improve patient pathways using technology to transfer patients to the service that best matches their clinical need.  

We are working in collaboration with the lead commissioner for the North West Ambulance Service to ensure appropriate response times (meeting contractual standards) are met by improving despatch priority, for example by improving the telephone triage processes  

Build on the success of the Emergency Department Clinical Coordinator initiative which has worked alongside AED team to aid handover, and give additional support to ambulance crews and the AED team by providing advice on avoidable conveyance and alternative services |
| Providing timely access to high quality elective care | 18 weeks RTT has been sustainably delivered since CCG authorisation and we will continue to work with local Providers to maintain this performance. This is reviewed monthly at contract meetings and managed to clearance time and backlog clearance rate measures. Commissioned activity is sufficient to meet projected demand and contract meetings have agreed activity plans to continue delivery.

We continue to ensure patients receive independent choice of Provider and are empowered to make decisions about their care and where to receive it. This is delivered through the Choice Advisors working within the Warrington Referral Assistance Gateway. This will further optimise 18 week pathways particularly in orthopaedics.

Aligning with the work underway as part of the Women’s and Children’s Services Vanguard we will commence implementation of the recommendations in the Better Births report. |
|---|---|
### NHS Warrington CCG
### Five Year Forward View, the nine ‘must dos’:

| Improving the quality of care and access to Cancer treatments | A cancer action plan is in place with our local provider to ensure that any days delay in cancer pathways are reduced. Early detection events have been identified with regards to urology, head & neck and lung cancer pathways to improve both performance against target and one year survival rates.  

The CCG has successfully implemented a Cancer Rehabilitation Programme working with social and voluntary care agencies which will complement the Cancer Alliances to be established by NHS England.  

Our Providers deliver the 62 day maximum wait from receipt of urgent GP Referral to start of first treatment. We will devise a reporting tool to identify individual commissioner performance and work collectively with Providers to address inequalities which arise at a commissioner level. |
|---|---|
**Improving the quality of care and access to Mental Health and Dementia services**

To meet the Early Intervention Psychosis (EIP) standards a multi agency steering group has been established supported by the Regional EIP Lead. We are also a member of the North of England EIP Steering Group. We are working with partners to understand the investment required to meet the NICE approved care package standards and to define the data collection methodology.

Building on the positive improvement achieved in 2015/16, we will continue to meet Mental Health access standards. Dementia diagnosis rates will be maintained (Local Enhanced Service) and consistent access to effective treatment and support will be commissioned.

Working collaboratively to deliver our local CAMHS Transformational Plan will ensure early & timely access to high quality care with good outcomes and management of complex mental health issues. Commissioning of a new Eating Disorder Service has commenced that is fully compliant with National guidance. This new service will commence in Q3 2016.
**NHS Warrington CCG**  
**Five Year Forward View, the nine ‘must dos’:**

| Transforming Care for people with Learning Disabilities | We are working in partnership with the Local Authority and independent providers to develop new services. These services will meet and support the needs of individual’s who display challenging behaviours within the community setting. For more complex individuals we are developing solutions across the Five Boroughs footprint to minimise out of area placements.  
A health facilitator has been appointed to ensure people with Learning Disabilities are registered with a GP and that they have an annual health check.  
The Local Enhanced Service will provide additional nursing time to improve cervical, breast and bowel cancer screening rates for Learning Disability patients.  
We will monitor the quality of services accessed by people with a Learning Disability (and their mortality rates) through our contract management processes. |

| **Tackling Obesity and preventing Diabetes** | A clinical lead has been appointed to work with partners to validate and identify the type 2 Diabetes cohort within Warrington.  

The local diabetes pathway will be enhanced; targeted at people identified as high risk to help to modify their diet, control their weight, and become physically more active.  

Working with Public Health the CCG will target resources to ensure equitable access.  

The new Local Enhanced Services offered to practices includes a requirement to deliver proactive coordinated care for patients living with a long term condition such as diabetes. |
Financial Context

Financial Plan Overview:

- Exit 2015/16 with 1% surplus
- Distance from target reduced to (1.45%) or £3.8m
- BCF contribution exceeds minimum requirement
- £5.4m (2%) QIPP challenge identified
- Builds in activity growth based on both historic trends and provider consultation
- Despite a lower than expected funding allocation, the CCG’s Financial plans deliver NHS England business rules in full
- Provider economic models used in consultation with main acute provider to identify cost improvement opportunities aligned to CCG change programmes
- Development of a shared control total for the Warrington Health Economy during 2016/17.
Operational Delivery 2016/17

Delivering High Quality & Constitutional Standards:

- Outcomes based contract in place for Out of Hospital Services in 2016/17
- 3 year contracts awarded in 2016/17 with all providers
- Strong management of national and local quality measures (including NHS constitutional Standards) within contracts
- Working in collaboration with regulators, Providers are managed and monitored via monthly contract quality meetings and through announced and unannounced Provider visits
- Clinical quality focus groups themed to address areas requiring improvement involving provider and commissioning clinicians
- Regular clinical audits undertaken jointly with Providers for additional Quality Assurance
- 3 year CQUIN agreed across all Providers to focus on the management of frailty to support integrated pathways of care to improve outcomes for vulnerable patients
Harnessing Information & Technology:

- SystmOne provides online patient access to 20 practices which will enable the CCG to meet the minimum threshold for Primary Care services online.
- Implementation of new Patient Administration System in 2015/16 at our main acute Provider has enabled the design of bespoke electronic discharge summaries.
- Multi agency (including Local Authority partners) digital care record procurement is proceeding to full business case. This will see the implementation of an integrated care record portal which will build on the current access to the summary care record.
- In June our local health economy roadmap will be published to demonstrate how we will achieve a paper free NHS.
- Referral Assistance Gateway will increase NHS e-Referral rates.
Operational Delivery 2016/17

Capability & Infrastructure for Transformational Change:

- A local estates strategy was completed with all partners in March 2016
- A Strategic Estates Partnership Board was established during 2015/16 and is led by the CCG
- As part of the 2016/17 Organisational Development Plan the CCG is undertaking a skills audit of the workforce to identify leadership and development opportunities
- The CCG is a member of the Alliance Local Delivery System (LDS) group that sits within the Cheshire & Merseyside STP footprint
- The CCG will focus on the current and future workforce when planning service transformation and redesign to ensure that we have a workforce with the right skills and behaviours to deliver commissioned services now and in the future
- A task force has been established to review and revise the CCG’s Assurance Framework to ensure congruence with new NHS England requirements
Operational Delivery 2016/17

Personalisation & Choice:
- Through the 2015/16 assurance process we have demonstrated our commitment to improving the offer awareness and take-up of Personal Health Budgets
- We plan to explore other areas where there may be benefits for the patient and their carers, for example end of life care
- The Warrington Referral Assistance Gateway will support informed patient choice by making available quality information for a wider range of Providers

Commissioning Development:
- The CCG aims to take on fully delegated commissioning of Primary Care during 2016/17 and has established a Primary Care Support Team and Co-commissioning Board
- The CCG is an active member of the Cheshire & Merseyside Specialist Commissioning Oversight Group
- NHS Warrington CCG, with specialised commissioners, led on the development of a hub and spoke model for spinal services. This forms the basis of The Walton Centre’s vanguard value proposition for a spinal network
- Following the NHS England Lead Provider Framework process we have successfully appointed Midlands and Lancashire CSU to work with us
Science & Innovation:

- Enhancing the mobility and capacity of the workforce by the use of new mobile technologies and the implementation of a shared wireless network across community and hospital services
- The CCG will contact the North West Cost Genomics Medicine Centre to explore areas where we can support their work
- NHS Warrington CCG is an active and enthusiastic member of the NWAHS network, recognising and utilising its valuable role in promoting innovative and effective adoption of new ways of working and new technologies that improve health outcomes
- The CCG is developing new models of care via the Cheshire and Merseyside Women’s and Children’s partnership, the Neurology Vanguard and the development of collaborative clusters in primary care
Visual Overview
Primary Care

- Further develop our seven GP Clusters and primary care services around identified populations
- Implement pharmacists in General Practice to support the delivery of sustainable primary care services by integrated working approaches and workforce skill mix
- Consolidation of extended hours GP access to support our commitment to a 7 day NHS offering evening and weekend access
- Using Primary Care Infrastructure Funding we will implement the priorities identified in the CCG Estates Strategy
- Demonstrate improvement in patient satisfaction through improving access and use of technology

Impact:
- Increases accessibility of primary care services
- Reduces acute activity
- Manages pro-active care
- Contributes to improved wellbeing and quality of life for service providers and patients
- Works towards achieving sustainable Primary Care
- Facilitates Care Closer to Home
- Achievement of this element of the Quality Premium
Acuity/Complexity Model of Care
New Local Enhanced Services: ‘Warrington Brand’

- Collaborative working across primary care will deliver a range of projects to transform care delivery
- The enhanced service will provide core access standards that meet best practice
- Where appropriate, ambulatory care pathways will be managed in Primary Care
- Practices will be required to work with the CCG’s Medicines Management team to deliver consistent prescribing practice
- Membership engagement to deliver maturity of the collaborative clusters
- Increase identification and early treatment of lifestyle related health problems
- Effective Referrals utilising the Assistance Gateway
  - Improve the quality of care and access for patients with a mental health issue, dementia or a learning disability
  - Diagnostic bundle to be offered in Primary Care to include ECGs, spirometry, ambulatory blood pressure readings, 24hr ECGs and phlebotomy
  - Using risk stratification to support complex patients
New Local Enhanced Services: ‘Warrington Brand’

Impact:
- Supports sustainability and viability of primary care
- Promotes multi agency working resulting in potential efficiencies
- Reduce acute sector activity
- Focuses resources for maximum benefit and return on service investment
- Contributes to pro-active care, improved wellbeing and quality of life
- Reduces reliance on reactive primary care / community service provision by pro-active interventions
- Promotes patient self-care
- Reduces long term care needs
Our Map of the Future - Overview
Community Services

- Restructure services around practice populations and continue development of the acuity model
- Redesign and integration of urgent care primary care model to include GP OOHs, Extended Access and Acute Visiting Service
- Review and re-specify Care Home Support Service
- Commission high quality clinical assessment, care and treatment services
- Reduce reliance on secondary care services (as the main component of healthcare provision)
- Work across organisational boundaries to deliver integrated models of care
- Utilise telehealth/ telecare and integrated IT solutions to maximise efficiency

**Impact:**
- Increases consistency and quality of service provision
- Promotes multi agency working and resulting potential efficiencies
- Reduces acute sector activity
- Proactive management of complex care home residents reducing demand on other services
- Contributes to improved wellbeing and quality of life
- Maintains people safely in their home environment wherever possible
Change
Programmes
Collaborative Clusters

Collaborative Clusters will:

- Be supported by dedicated Service Development Managers
- Help build capacity at cluster level for development of a fully mature acuity model
- Share data and intelligence to create a joint approach; for example care for older people with complex needs
- Provide tailored care for patients by using intelligence from various data sources such as chronic disease registers and risk stratification
- Develop Care Co-ordination that will be provided by a range of professionals employed across a number of organisations including the voluntary sector.
- Reduce demand for GPs, practice staff and community services by directing and referring patients into care co-ordination services to help with a range of support needs

Impact:

- Aligning staff and build additional capacity through care co-ordination
- Support independent living and reduce the use of hospital services
- Support for patient’s, families and carers to navigate the health and social care system
- Enhance choices around self-care and self-management
- Supports informed decision making
- Supports sustainability of a multi-disciplinary workforce
Integrated GP OOH & Extended Access

- Work commenced March 2016 to redefine and re-commission the Urgent Primary Care model which includes the integration of GP OOHs, Extended Access and the Acute Visiting Service
- Explore new models of care and skill mix to deliver sustainable services in the community
- Ensure people receive the right level of care in the right place by the right professional
- Consolidate services to reduce duplication, aid recruitment & retention of the workforce
- Offer other integration opportunities, for example with the Enhanced Care Home support service redesign, NHS 111 and clinical advice hubs

**Impact:**
- Reduces avoidable attendance at A&E
- Supports viability and sustainability of primary care provision
- Improved primary care access
- Supports future workforce planning to enable long term stability of services
- Improves quality, outcomes and value for money
- Increases capacity without increasing cost
Enhance Care Home Support

- Review, redesign and re-specify the Enhanced Care Home Support Service including but not limited to Single Point of Access (SPA)
- Embed support for care home residents across other care pathways e.g. end of life care and other community services
- Undertake a comprehensive skills audit to match skill sets to identified service needs to ensure maximisation of available resources
- Explore integration with other developing service models, for example GP OOHs, Extended Access and Out of Hospital services sector
- Multi disciplinary team approach including medicines management and social care

**Impact:**
- Proactive care for care home residents resulting in optimal management
- Reduction in avoidable poly-pharmacy
- Increased capacity within Primary Care to allow focussed management of complex patients
- Increase the quality of care in the Care Home Sector by identifying and addressing development and capability gaps
Step Up Pathways

- A key element of the new Integrated Out of Hospital sector
- Wraps appropriate services around the individual to ensure that care is provided in the right setting
- Acute care accessed only when absolutely necessary
- Delivered by multi skilled, multi disciplinary teams through new workforce solutions
- Part of the continuum of care within the acuity model with citizens at the centre
- Particularly relevant at critical times such as acute deterioration in long term conditions

**Impact:**
- Reduction in non-elective admissions
- Delivery of care closer to home for citizens
- Multi-skilled, multi-disciplinary workforce is developed and retained
- Integrated approaches to care delivery achieved, new models of care
- Sustainable and viable service provision
Right Care: Neurological

- Use ‘Right Care’ methodology to help address issues of quality, value and outcomes for this speciality, where the CCG is identified as an ‘outlier’ (focus pack due end April ‘16)
- As a Vanguard Board member, we will work within the Walton Centre ‘Neuro Vanguard’ to identify key interventions, define the desired impact of pathway & service redesign and implement key changes
- We will collaborate with providers, commissioners and primary care to maximise available resources to enhance identified pathway and service changes
- Test redesigned neuro pathways and services in identified ‘Primary Care Home’ cluster/s and evaluate impact in year
- Roll out redesigned pathways & services that have demonstrated desired outcomes to additional clusters

**Impact:**
- Reduction in avoidable acute activity
- Reduced avoidable variation in condition management
- Adoption of best practice in neuro care
- Care delivered closer to home for patients
- Contributes to the sustainability of the whole system
Right Care: Trauma & Injury

- Use ‘Right Care’ methodology to help address issues of quality, value and outcomes for this speciality, where the CCG is identified as an ‘outlier’
- Use ‘Deep Dive’ analysis report to identify areas needing particular focus to redesign pathways or services (focus pack due end of May ‘16)
- Identify and implement key interventions, defining and monitoring the desired impact of pathway & service redesign
- Use resources within the Walton Neuro Vanguard to enhance revised pathway & service implementations
- We will maximise available resources by close working with Public Health to achieve reduction of falls and the impact of alcohol / substance misuse resulting in trauma and injury

**Impact:**
- Reduction in avoidable acute activity
- Increased quality of life for patients / citizens
- Reduced avoidable variation in condition management
- Care delivered closer to home for patients
- Contributes to the sustainability of the whole system
Right Care: Gastrointestinal

- Use ‘Right Care’ methodology to help address issues of quality, value and outcomes for this speciality, where the CCG is identified as an ‘outlier’
- Use ‘Deep Dive’ analysis report to identify areas needing particular focus to redesign pathways or services. Midlands and Lancashire CSU to produce focus pack (in quarter 3)
- Identify and implement key interventions, defining and monitoring the desired impact of pathway & service redesign
- Maximise available resources by close working with Public Health to achieve reduction of the impact of alcohol / substance misuse

**Impact:**
- Reduction in avoidable acute activity
- Adoption of best practice pathways and treatments
- Increased quality of life for patients / citizens
- Reduced avoidable variation in condition management
- Contributes to the sustainability of the whole system
Control
Programmes
Visual Overview of 2016/17 Control Programmes

- Cancer
- End of Life
- Mental Health
- Urgent Care
Cancer

- Develop the Cancer Rehabilitation Programme to incorporate Cancer Survivorship
- Work with providers to improve staging data reporting
- Work with GP’s on protocol for appropriately prescribing chemo-preventative agents to reduce the risk of invasive breast cancers
- Assess feasibility of colorectal two week waits going straight to CT colonoscopy and develop protocol & pathway
- Commission education programmes for Practice Nurses, raising awareness of cancer care, signs and symptoms – developing key worker in primary care and deliver cancer care reviews
- Develop a local cancer services directory
- Implement Health needs assessments for all those diagnosed and living with cancer

**Impact:**
- Raised awareness of cancer for patients and health professionals
- Improved patient outcomes from earlier detection and diagnosis
- Improve the wellbeing and Quality of Life for cancer patients and survivors by providing appropriate support
- Reduce the number of cancers identified via unplanned care / AED attendance
End of Life

- Commission an integrated End of Life Care Pathway,
- Explore new care models and contracting methods e.g. alliance / prime provider
- Increase use of up to date advanced care plans in all settings
- Increase MDT Gold Standards Framework (GSF) meetings in GP practices
- Work with all stakeholders to develop a multidisciplinary workforce sufficient in number and skill mix to provide high-quality end of life care and support
- Implement EPaCCs (Electronic Palliative Care Co-ordination Systems)

Impact:
- Reduces avoidable admissions for patients at end of life
- Contributes to achievement of the AED standard
- Facilitates patients to die in preferred place
- Facilitates patient choice at end of life
- EPaCCs will enhance inter professional communication and improve quality of care
Mental Health

Implement the recommendations from the Mental Health Strategy 2015/18:

- Review current pathways into and out of services to improve access and use of resources
- Identify solutions to deliver local management of people with complex needs
- Increase to 100% the number of crisis plans in place
- Commission mental health awareness training for all primary care and third sector colleagues
- Investigate option for a web-based, Mental Health information portal
- Develop a crisis house business case and secure funding via the Better Care Fund
- Implement a primary care pilot to improve management of patients with Medically Unexplained Symptoms
- Working with % Boroughs Partnership, appoint a Consultant Psychiatrist to the Liaison Psychiatry Service to develop appropriate pathways, data recording and defined outcomes to improve overall uptake
- Work with partners and stakeholders to ensure new targets for Early Intervention in Psychosis and Improving Access to Psychological Therapies are met

Impact:

- Reduce avoidable AED attendance, contributing to AED standard achievement
- Maintain reduction in the use of Section 136
- Provide care close to home and improve outcomes
- Improve capability of the workforce to provide care for patients with MH issues / parity of esteem
- Use technology to enhance available clinical resources
Urgent Care

- Redesign integrated GP OOH, Extended GP access & Acute Visiting Services to achieve a streamlined pathway with single point of access
- Explore 111 as part of integrated service, potentially as single point of access
- Improve the ‘See & Treat’ clinical models for the ambulance service
- Work with our main acute provider to implement consistent Ambulatory Emergency Care model and Frailty pathway
- Develop pathways with new ‘Out of Hospital Services’ model to improve community interventions and avoid unplanned acute activity

**Impact:**
- Reduce avoidable AED attendances
- Aids delivery of Accident and Emergency Constitutional Standard
- Offers better primary care access to patients
- Provides care close to home delivered by the right professional
- Reduces avoidable conveyances
- Reduces duplication, enhances skill mix and offers economies of scale
- Delivers robust, sustainable services
Key Documents

- Strategic Commissioning Plan 2014/19
- Joint Strategic Needs Assessment
- NHS Five Year Forward View
- Warrington Health & Wellbeing Strategy 2015/18
- NHS England Business Plan 2016/17
Excellence for Warrington