NHS
Central London
Clinical Commissioning Group

Central London CCG

Contracting intentions 2015/16

V. 12.0

Version	Date	Owner
1.0	3/09/14	MJ
2.0-4.0	22/9/14	DV
5.0	24/09/14	DV
6.0	25/09/14	KC
7.0	25/09/14	DV
8.0	26/09/14	CP
9.0-12.0	23/10/14	DV

Contents

Introduction

The purpose of this document is to set out for providers the priority contracting intentions for Central London Clinical Commissioning Group for 2015/16, which will inform contract negotiations. This document should be read in the context of the CCG's wider commissioning plans and with reference to the strategic context set out in the next section.

A further document aimed at the general public (the commissioning intentions) will be published in December.

This document is structured in 8 sections.

- Section 1, provides the strategic context of these plans;
- Section 2, outlines the CCG's approach to the contracting round;
- Section 3, summarises the strategic priorities for 2015/16, across particular areas of delivery;
- Section 4, identifies key quality and outcome improvements;
- Section 5, sets out high-level procurement plans;
- Section 6, focuses on local pathway priorities;
- Section 7, summarises the above intentions; and,
- Section 8, outlines equality impacts of the above plans.

For added transparency, Appendix 1 includes a glossary of most common acronyms used in this document.

1. Strategic context

The eight CCGs in North West London, with our local authorities and other partners, are in the process of implementing wide scale changes to the way in which patients experience and access health and social care. These plans are ambitious and transformational, and the vision is set out below.

We want to improve the quality of care for individuals, carers, and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

This vision is supported by 3 principles:

1. *People and their families will be empowered to direct their care and support and to receive the care they need in their homes or local community*

2. *General Practitioners ('GPs') will be at the centre of organising and coordinating people's care*

3. *Our systems will enable and not hinder the provision of integrated care.*

We started the implementation of this vision in 2013/14, and have been putting many of the fundamental building blocks in place during 2014/15. Some of the key enablers have been:

- Primary Care Navigators, Community Independence Service and care planning through Wellwatch;
- 7 day working in primary care and social care;
- Development of GP federations, which has commenced in 2014/15;
- Development of Out of Hospital contracts, which will be commissioned at network/locality level later in 2014/15, replacing practice level local enhanced services and ensuring wider population coverage;
- Closure of Hammersmith Hospital Emergency Department and Central Middlesex A&E unit;
- Implementation of a single GP IT system, SystmOne, across the majority practices in Central London, with all practices due to migrate by December 2014;
- Establishment of whole system integrated care early adopters, with business cases for implementation from April 2015 being developed; and,
- Contracts with all key NHS providers that incentivise the transformation of services and the movement of services out of hospital.

We intend to build on this further during 2015/16.

2. Approach to the contracting round

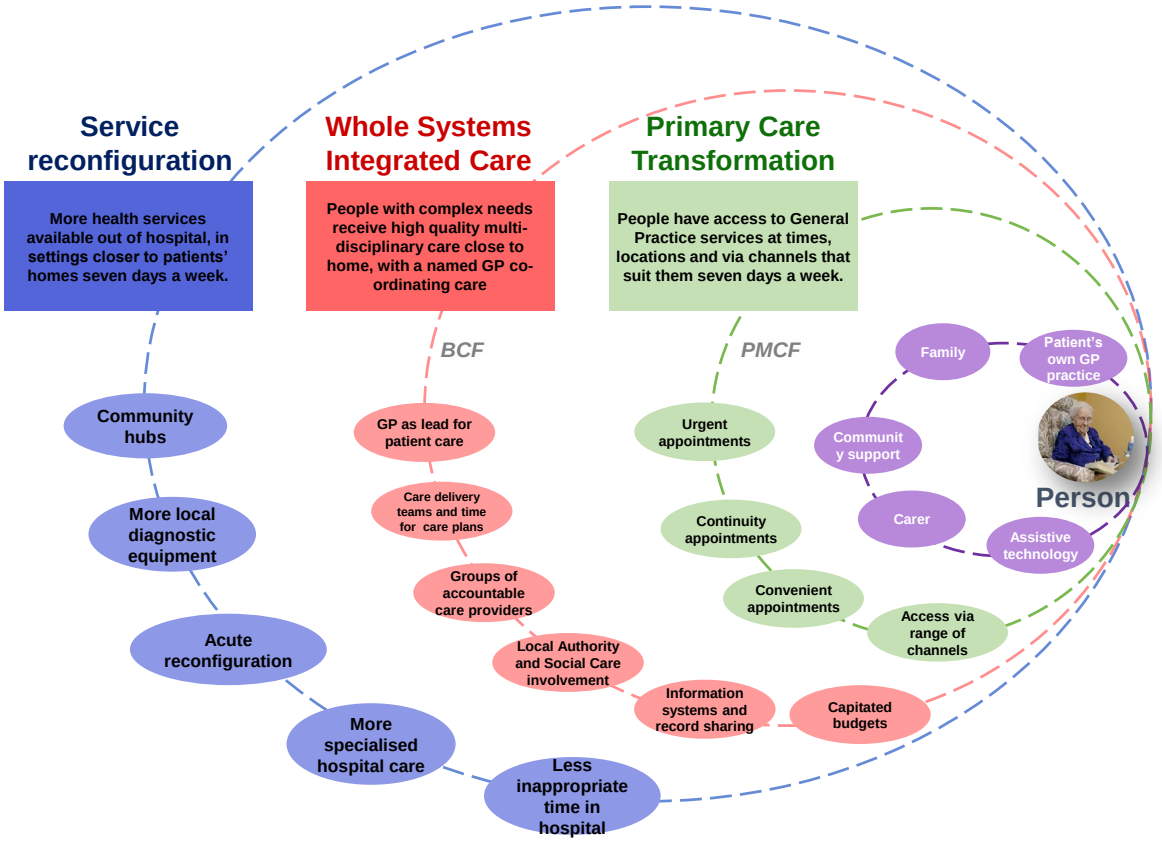
Our approach to the contracting round will build on the approach taken in 2014/15. We will be working closely with the other CCGs in the collaborative (or 'CWHHE', the working partnership between Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups), and also with our colleagues in Brent, Harrow and Hillingdon, to maintain strategic alignment. Our primary objective is the delivery of our strategic vision, and we expect to negotiate contracts that will support us in the delivery of that vision, with a focus on transformational change and service integration. We will expect our providers to demonstrate how they are transforming their services to meet that challenge and how they are moving towards the Shaping a Healthier Future ('SaHF') service standards. We will seek to ensure that the incentives and penalties within contracts are aligned to ensure the delivery of the required transformation. All CCGs in NWL have whole systems integrated care early adopters who are developing models of care, and we expect to commission these during 2015/16, either in shadow or live form. We expect to reflect this within our 2015/16 contracts with the relevant providers.

Patient empowerment, and putting the patient at the heart of all we do, is fundamental to our vision. Generally providers are not doing this at present. We will seek to embed a requirement for much greater patient focus within our contracts for 2015/16.

We intend to start our contract negotiations earlier for 2015/16, with the aim of agreeing the baseline activity and many of the schedules before Christmas, subject to any changes that may be required as a result of the publication of planning guidance and 2015/16 tariffs in late December. This will give us the opportunity for better quality discussions and earlier certainty regarding 2015/16, enabling better planning and therefore a greater chance of delivery of the agreed changes. We expect all contracts to be signed by 31 March 2015.

3. Strategic Priorities for 2015/16

Our vision is underpinned by the 4 key work streams of i) Service reconfiguration under *Shaping a Healthier Future*; ii) Whole Systems Integrated Care; iii) Primary Care Transformation and iv) Patient Empowerment. This is shown in the diagram below.



We are currently developing the 5 year roadmap that sets out all the key milestones over the next 3-5 years to ensure that the vision is realised. The following section sets out the delivery priorities and milestones for 2015/16 against each of these key programmes.

3.1. Service Reconfiguration

Shaping a Healthier Future, the acute reconfiguration programme in NW London will centralise the majority of emergency and specialist services (including A&E, Maternity, Paediatrics, Emergency and Non-elective care) to deliver improved clinical outcomes and safer services for our patients. Agreed acute reconfiguration changes will result in a new hospital landscape for NW London. The SaHF Reconfiguration programme will oversee:

- The existing hospital landscape of nine hospitals reconfigured to provide five Major Acute Hospitals;

- Ealing and Charing Cross sites redeveloped, in partnership with patients and stakeholders, into Local hospitals;

- Hammersmith Hospital established as a specialist hospital; and

- Central Middlesex Hospital will be redeveloped as a Local and Elective Hospital.

Clinical standards

The programme supports the achievement of enhanced clinical standards. As part of the original development of NW London's vision, NW London's clinicians developed a set of clinical standards for Maternity, Paediatrics, and Urgent and Emergency Care, in order to drive improvements in clinical quality and reduce variation across NW London's acute trusts.

These clinical standards, along with the London Quality Standards and the national Seven Day Services Standards, will underpin quality within the future configuration of acute services, including along the urgent and emergency care pathway. North West London is committed to delivering seven day services across the non-elective pathway by March 2017, based on the national clinical standards, in order to improve the quality and safety of services and to support emergency care flow.

The acute reconfiguration is dependent on significant take-up of existing and new out of hospital services being delivered locally by all CCGs to ensure that patients only go to hospital when they need to.

As part of a common commitment across NW London, CCGs will commission services from Acute Trusts that meet the agreed clinical standards, including those defined by the Shaping a Healthier Future programme, London Quality Standards, and national Seven Day services standards. In 2014/15 the baseline of delivery against the Seven Day standards has been established, and a NWL prioritisation has been agreed to guide the sequencing of Seven Day standard achievement through until March 2017.

As of April 2015, all Acute Trusts will meet the following seven-day standards:

- Time to first consultant review: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

- On-going review: All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate.

- Diagnostics: Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be

available seven days a week: within 1 hour for critical patients; within 12 hours for urgent patients; within 24 hours for non-urgent patients

In addition, Acute Trusts will be expected to produce quarterly patient experience reports that compare feedback from weekday and weekend services.

Over the course of 2015/16, Acute Trusts will work towards achieving the following seven-day standards:

- Multi-disciplinary Team review: All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

- Shift handover: Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

All providers across primary, community and social care will work towards seven-day discharge pathways – e.g. that support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

2014/15 service changes

Following the 'full' support of the Secretary of State in October 2013 and after the review of the Independent Reconfiguration Panel, priority service changes are being delivered in 2014/15:

- Transition of services from the Emergency Unit at Hammersmith Hospital

- Transition of services from the A&E at Central Middlesex Hospital

- All Urgent Care Centres ('UCCs') moved to a common operating specification, including a 24/7 service

The programme has also been undertaking contingency planning for the potential transition of Maternity and Paediatrics services at Ealing Hospital.

Contracts for 2015/16 will reflect the full year effect of the changes above.

OBC development

Outline Business Cases (OBCs) will be developed and centrally reviewed for all sites in 2014/15 (major and local hospitals). Additionally, the programme is also developing an Implementation Business Case (ImBC) to ensure that the refined solution for NW London remains affordable and aligned with the clinical vision. OBCs for Major and Local Hospitals are expected to be approved by NHSE, NTDA, DH and HMT in 2015/16, and following this Full Business Cases will be developed to allow the redevelopment of sites to continue.

Out of Hospital services

Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs are working together to enable transformation within primary care across the CWHHE collaborative. Each CCG has an Out of Hospital ('OOH') strategy that describes keeping the patient at the centre of their own care, with the GP as a key provider and coordinator of services. In addition, key strategic priorities for the CCGs are to improve quality, reduce variation within primary care and ensure all patients within the CCG have equity of access to commissioned services. The CWHHE collaborative has therefore agreed to realign services to support the delivery of the OOH strategies, including the commissioning of a consistent range of services – an OOH portfolio - from GP networks. The portfolio comprises the following services:

Table 1 Portfolio of Out of Hospital Services

Services	
Ambulatory Blood Pressure Monitoring ('ABPM')	Diabetes (High Risk)
Access	Electrocardiogram ('ECG')
Anti-Coagulation Monitoring	Homeless
Anti-Coagulation Initiation	Near patient monitoring
Care planning	Phlebotomy
Complex common MH	Ring pessary
Complex wound care	Severe and enduring MH
Diabetes Level 1	Simple wound care
Diabetes Level 2	Spirometry Testing
Diabetes (High Risk)	Spirometry Testing

The table below describes the services to be commissioned through the Out of Hospital Services commissioning programme. The unit construction method, indicative current service impacted, and total expected activity volumes for a full year for the CCG are shown. Please note that we do not expect a full year of activity to be transferred in 2015/16 as we will be phasing roll out. We will work with providers over the next three months to define

how each provider will be impacted. Where services are predicted to meet 100% population coverage, decommissioning notices will be issued to current providers, as appropriate.

Table 2 Portfolio of Out of Hospital Services – Expected Provider impacts

Central London OOH Services	Activity Forecast: 100% coverage	Activity Type (contact or package)	Acute Point of Delivery (POD)
ABPM	4,000	Per test	Cardio OPD
Anticoagulation Monitoring	1,935	Package p.pt p.a (FA+12FU)	Clin Haem OPD
Anticoagulation Initiation	829	Package p.pt p.a (FA+8FU)	Clin Haem OPD
Case Finding, Care Planning & Case Management	3,950	Per patient	N/A
Complex Common Mental Health Management	1,792	Package p.pt p.a (FA+7FU)	N/A
Complex Wound Care	208	Per contact	Various
Diabetes (Level 1)	5,923	Package p.pt p.a (FA+2/3FU)	Diabetes OPD
Diabetes (High Risk)	3,700	Package p.pt p.a (+2appts)	Diabetes OPD
Diabetes (Level 2)	178	Package p.pt p.a (FA+2FU*)	Diabetes OPD
ECG	4,463	Per test	Cardio OPD
Homeless	1,916	Package p.pt p.a (FA+11FU)	A&E/ NEL
Near Patient Monitoring	908	p.pt p.a	Rheum OPD
Phlebotomy	64,499	Per venepuncture	
Ring Pessary	407	Per ring p.pt p.a	Gynae OPD
Simple Wound Care	2,080	Per contact	Various
Spirometry Testing	3,259	Per test	Respir OPD
Transfer of Care: Severe and Enduring Mental Illness	296	Package p.pt p.a	N/A

Source: CLCCG

Mental Health Transformation

In 2015/16, CCGs wish to see continued implementation of the Shaping Healthier Lives 2012-15 core initiatives including:

- **Urgent Care**: Roll out of the Single Point of Access ('SPA') and 24 hour, seven-day access to home-based urgent assessment and initial crisis resolution work.

- **Liaison Psychiatry**: Further benchmarking of services to drive increased standardisation of investment, activity, impact and return on investment.

- **Whole Systems/Shifting Settings**: Building upon work to date to implement Primary Care Plus, test, refine and roll out a new model of 'community staying well' services for people with long-term mental health needs. This entails providing the GP (as accountable clinician) with a range of care navigation, expert primary mental health and social integration/recovery support services to deliver care closest to home and prevent avoidable referral to secondary care.

In 2014/15, the Transformation Programme Board has sponsored development work streams in dementia, learning disability, perinatal mental health and Improving Access to Psychological Therapies ('IAPT'). CCGs will expect providers of these services to implement the key pathway, models of care and quality standards that emerge from these work programmes. The Board has also sponsored a review of Child and Adolescent Mental Health Services (CAMHS) Out of Hours Services; based on the outcomes of this review we will commission services to address current disjoints, this may involve re-commissioning collaboratively with the other NWL CCGs a new provider of service. This review is due to be complete early autumn 2014.

In June 2014, the Collaboration Board supported the need for co-ordinated, system-wide change in NWL as the best way to achieve our vision for mental health and wellbeing services, ensuring mental health has an equal priority with physical health, and that those with mental health needs get the right support at the right time. . It agreed that a programme of work should be delivered to address the strategic challenges and opportunities facing mental health and wellbeing services in NWL. Since then, engagement has been undertaken with a wide group of stakeholders to gauge their interest in the programme and their views regarding its scope and the timescales within which each stage of the programme could be achieved. Stakeholders include all NWL CCGs and Local Authorities, WLMH, CNWL, Directors of Public Health, members of the Mental Health Programme Board, Lay Partners and Imperial College Health Partners.

Overall enthusiasm and commitment has been high whilst recognising the need to ensure alignment with existing local programmes and priorities and national initiatives. In September the Collaboration Board noted progress on development of the NWL Whole System Mental Health and Wellbeing Strategic Plan and endorsed a Programme Initiation Document setting out the governance arrangements, overall timetable and the resourcing requirements to deliver this exciting and important piece of work. The programme will likely commence in November 2014, with a case for continuity and change produced six months afterwards, and

options for change six months after that. There may be a need for public consultation depending on which options are developed.

3.2. Whole Systems Integrated Care

In the summer of 2013, along with partner organisations across North West London ('NWL'), we committed to a vision to create "better coordinated care and support, empowering people to maintain independence and lead full lives as active participants in their community." The Whole Systems Integrated Care ('WSIC') programme was established to achieve this shared vision. As indicated in our commissioning intentions last year, an extensive programme of co-design ran through 2013/14, which included partners from health and social care organisations across NWL, service users and carers.

NWL is one of fourteen national integrated care 'Pioneers'. We are currently developing detailed local plans in order to begin implementation in 2015/16 and will continue our commitment to collaboration and co-production with our partners. We anticipate that our transition to full Whole Systems Integrated Care will take three to five years, at which point we will be:

- Commissioning fully integrated models of care based on the holistic needs of different population groups, encompassing both health and social care

- Jointly commissioning for each population group a set of outcomes across health and social care, with a single, combined, capitated budget to achieve them. Through capitation, we will support service users to access a personal budget for health and social care needs as agreed through the development of a personalised care plan

- Commissioning a group of providers to offer an integrated care service to the population groups. We anticipate that these providers will work together as an Accountable Care Partnership ('ACP') and be held collectively accountable for achieving the commissioned outcomes and managing the associated financial risk for the population groups.

In 2015/16, we will begin to move towards Whole Systems by implementing elements of a new model of care, employing a joint commissioning approach and continuing to work collaboratively with providers to support the development of ACPs. We expect to reflect the agreed model of care and payment arrangements in the 2015/16 contracts for the relevant providers.

All providers will continue to have the opportunity to participate in the development of WSIC through a collaborative, iterative process. Through on going co-production with both our partners and service users, we will continue to build towards a model of integrated care that best meets the needs of our residents. We expect providers currently working with population groups in our local area to respond to these intentions.

In Central London CCG, we have agreed through our Early Adopter partnership to start by focusing on over 75s and healthy, over 75s with a long term condition and under 75s with a

long term condition. Therefore, in 2015/16 the following will be within the scope of the new model of care for these groups:

- Primary care
- Social care
- Secondary care
- Community
- Mental health
- Voluntary/third sector

We will continue to work with all partners through co-production to ensure alignment between the development of WSIC and the implementation of the Better Care Fund.

Better Care Fund

The Better Care Fund (BCF) is a key enabler for Whole Systems Integrated Care, and is being taken forward across the Tri-borough through four major workstreams:

- Integrated Operational Services, including Community Independence Service Plus, 7-day working, and Homecare
- Service User Experience
- Integrated Community Contracting and Commissioning
- Programme Delivery, including IT and implementation of the Care Act 2014.

Two major schemes within the BCF that are particularly significant for Hammersmith & Fulham are described below. These schemes represent a continuation of the direction we set out in our commissioning intentions for 2014/15; they are aimed at addressing increased demand and complexity of need amongst older people as well as improving efficiency and reducing duplication, the schemes are:

a. Transforming nursing and residential care home contracting
b. The integrated crisis response/community independence service (ICR/CIS).

These services are outlined below.

a. Transforming Nursing and Residential Care home contracting. The Tri-borough CCGs and Local Authorities will develop their proposals to integrate the functions of commissioning, contracting and assuring the quality of care home placements across the three boroughs. Within Tri-borough, there is currently no consistent approach to contracting, brokerage and monitoring of placements whether funded by Adult Social Care or Health and this results in a lack of alignment with regard to contracting, safeguarding and quality assurance resources, intelligence and expertise.

   Our proposal for a single integrated commission team will eliminate gaps, duplication and disconnects across Nursing and Residential Care placements by creating a consistent, joint approach to contracting, safeguarding and escalation, and oversight of the sector, tailoring and focusing care around the individual.

In 2015/16 we will:

- Integrate the contracting and brokerage functions for Nursing and Residential Care placements across adult social care and health, creating a single team. Under this arrangement CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements.
- Align the teams that undertake reviews of placements and that also gathers and monitors provider data and intelligence. This will include intelligence about the quality of placements and safeguarding concerns
- Work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction

Within the scope of this project is:

- Integration of the contracting and brokerage functions across Local Authority and Health placement teams, including:
  - Funded Nursing Care (FNC)
  - Non-residential Continuing Health care placements
  - Residential Continuing Health care placements
  - Adult Physical Disabilities placements
- Feasibility evaluation of increasing delegated authority thresholds for Continuing Health care placements
- Improved monitoring and pooled intelligence around service provision
- Qualification and quantification of potential financial savings associated with a joint contracting/brokerage team (supported by improved provider intelligence)

b. *The Integrated Crisis Response / Community Independence Service.* As part of the Better Care Fund, the implementation of a Tri-borough Integrated Crisis Response and CIS will commence in 2015/16 with a transition year during which a phased approach will be taken with existing providers to work to a new single model service specification.

Following consultation with providers and co-design with patients on the proposed model and investment for 2015/16, commissioners will further specify how they will implement the recommendation set out in the detailed business case (September 2014), '*that the new investment of £7.4m would be packaged up and offered out to the existing set of providers, in order to appoint two lead providers (1 in social and 1 in health) to manage the delivery of the new service*'. For health, a process will be run between existing providers in order to appoint the lead provider who would then work together with the local authority lead provider in partnership to ensure delivery of a single integrated service.

In Quarter 3 of 2014/15, commissioners will inform existing providers of the process to select a lead organisation(s) and of their requirement to work together under a

formal agreement during 2015/16. This process will be completed by 1st April 2015 and will be informed by our work with patients in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model.

The lead provider (s) will need to demonstrate how they will ensure:

- A rapid response multidisciplinary team ('MDT') providing community care within two hours and for up to five days.
- Non-bedded community rehabilitation, treating non-complex conditions in a community setting.
- Integrated reablement with access to short term community beds between six and twelve weeks.
- Seven-day support to help people leave hospital.

3.3. Primary Care Transformation

A number of drivers have combined to create a pressing need to transform access to General Practice in NW London:

- **Patient expectations**: In a recent survey of NWL patient priorities for primary care, seven of the top ten issues related to improved access.
- **Implementation of the Shaping a Healthier Future reconfiguration programme**: The Independent Reconfiguration Panel ('IRP') report on NWL's Shaping a Healthier Future programme requires GP practices in NW London to move towards a 'seven day' model of care to support the agreed changes to acute services.
- **Contractual drivers**: With effect from April 2014, GMS contractual arrangements have been amended to reflect an increased emphasis on improved access to General Practice.
- **Financial drivers:** A consistent, system-wide access model has the potential to reduce costs for both commissioners (reduced service duplication) and providers (more efficient use of resources).
- **Legislative changes:** The approval of the Legislative Reform (Clinical Commissioning Groups) order 2014, allows CCGs to form joint committee when exercising their commissioning functions jointly; as well as enabling CCGs to exercise their commissioning functions jointly with NHS England via a joint committee.

- **Primary care strategic framework:** NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. On going, they will be used to support local transformation strategies

Though it may be part of the solution, expanding capacity alone will not improve access to General Practice. Any strategy for transforming access to General Practice must therefore comply with four overarching principles:

1. **System-wide reconfiguration of access to all 'General Practice'-type services:** the provision of additional urgent appointments outside of core hours is unlikely to lead to sustainable improvements to access. In order to ensure that we are able to deliver services that genuinely reflect patient needs and preferences, we need to be thinking about seven-day working across General Practice in its totality.

2. **Financially and operationally sustainable**: A new model must be affordable and deliverable. In the long-term this probably means no net increase in cost or workforce.

3. **Meets patient expectations**: A new model must deliver the type of appointments patients want, when they want them.

4. **Reconfigures both supply and demand such that both are mapped more closely to clinical need**: Though patient choice should be respected, every effort should be made to ensure that patients receive care appropriate to their clinical condition. This means mapping capacity more closely to clinical need.

NWL have resourced a Primary Care Transformation programme to take this work forward. The programme comprises 5 distinct workstreams, some of which are described below.

Prime Minister's Challenge Fund

CCGs in NW London were awarded funding through a successful application to the Prime Minister's Challenge Fund ('PCMF'). This is now a significant enabler for the delivery of NW London's vision for a transformed primary care landscape in allowing, through a combination of NWL and NHSE funding, an extension to GP access and continuity in the short term (by the end of 2014/15) as well as putting the right support in place to nurture and grow GP networks (in 2014/15 and beyond).

The Challenge Fund will focus on outcomes around Urgent and Community Care to ensure that patients have access to General Practice services at times, locations and via channels that suit them, seven days a week.

It is planned that the PMCF project will produce outcomes covering around the below principles.

Chart 1 Prime Minister's Challenge Fund principles and implementation guide

		Network responsibility	Implementation guide for 2014/15
URGENT CARE	• Patients with urgent care needs provided with a timed appointment within 4 hrs.	✓	Long term
	• Patients with non-urgent needs will be able to contact a clinician within 48hrs by phone, online or in person.	✓	Long term
	• Telephone advice and triage available 24/7 via 111.		
CONTINUITY CARE	• All individuals who would benefit from a care plan will have one.	✓	Medium term
	• Everyone who has a care plan will have a named 'care co-ordinator'.	✓	Medium term
	• GPs will work in multi-disciplinary networks.	✓	Medium term
	• Longer GP appointments for those that need them.	✓	Medium term
CONVENIENT CARE	• Access to General Practice 8am-8pm (Mon-Fri) and 6hrs/day during the weekend.	✓	Long term
	• Access to GP consultation in a time and manner convenient to the patient (via a range of channels including telephone, email and videoconference).	✓	Short term
	• Online appointment booking and e-prescriptions available at all practices.	✓	Short term
	• Patients given online access to their own records.	✓	Short term
	• Online access to self management advice, support and service signposting.		

We are doing this by supporting practices to develop strong networks and plans; so that by the end of 2014 / 2015 business cases will be available for a new model of care, and quick wins (e.g. around new applications for technology) will have been implemented. All PMCF activity is expected to align with changes in the GP contract agreement.

Primary Care Strategic Framework

NHS England has released a set of descriptors covering 3 areas – Accessible Care, Co-ordinated Care and Proactive Care. Further work is on going to refine and develop these as part of a pre-engagement phase.

The three areas are in effect a specification within a strategic commissioning framework to support local primary care transformation. This specification describes the service offer that patients could expect in the future across London, but it acknowledges implementation plans will need to be locally developed to meet the needs of different populations. In addition, it is expected that working in this way, will relieve pressure and therefore enable general practice to deliver the improvements in care, that they want.

It is now anticipated that these descriptors will be ready for wider engagement at the end of 2014. Our work is now focussed on engaging with stakeholders and understanding how the descriptors could support a new model of care.

3.4. Patient Empowerment

As part of the wider integration agenda with Adult Social Care, we have been working in partnership with patients, carers and voluntary organisations to co-design and commission a range of patient empowerment programmes. The programmes will be targeted at supporting people with long terms conditions to take more control of their health and wellbeing. The outcome of engagement has enabled us to identify and embed an approach to working with patients, service users, carers and stakeholders. Our approach is therefore:

- Collaborative: bringing together clinicians, staff, patients, service users and the community together as equal partners to develop and implement the BCF programme
- Evidence-based: engaging to co-design evidence based and locally appropriate solutions to promote integrated health and social care
- Asset-based : developing the capacity of patients, service users and the community to engage effectively in identifying needs, project planning and development, procurement, implementation and evaluation.
- Continuous and iterative: engaging to build and refine sustainable models for local delivery that reflect the needs and aspirations of local people and frontline staff

In terms of the programmes, these include the below.

Improving Experience of Integrated Care

The aim of this project is to monitor improvements in patient, customer and carer experience of integrated care by establishing an integrated system for capturing, using and integrating real-time patient, service user and carer experience and intelligence. The developed approach will be used to capture initial baseline intelligence of patient experience and continued monitoring of patient experience of integrated care, specifically regarding the Community Independence Service (CIS), and then eventually across wider transformation projects. This project will also support wider engagement and communications across the Better Care Fund and Whole Systems agenda by providing tools and support to facilitate effective engagement and co-design.

Embedding Self-Management

To support patients and communities to have greater control over their health and wellbeing by co-designing a package of self-management programmes and interventions with customers, more specifically we will:

- Commission new and expand existing evidence-based self-management programmes and co-design of condition specific self-management programmes to address gaps in service provision. We will do this by working in partnership with local 3rd Sector organisations.
- Deliver a workforce development programme on self-care and self-management to ensure that frontline

- Establish a central point of contact: To provide tailored support and sign-posting in the health and social care systems, for those with long-term health conditions and their carers

4. Quality and outcome improvements

4.1. Required performance and quality improvements

The table below sets out how Central London CCG will aim to improve quality through our contracting intentions.

Table 3 Key Quality indicators and targets

Provider Organisation	Quality improvements Identified	Possible Stretch targets
Central London Community Healthcare Trust	Referrals responded to during the day, twilight or night periods within 24 hours	Acknowledgement of complaints within 2 days of receipt
	Reduction in Grade 3 and 4 Hospital Acquired pressure ulcers	
	Root Cause Analysis outcomes and Serious Incident notifications	
CNWL	IAPT recovery rates	
	Performance of early intervention of new psychosis cases	
Other providers	Improvement in maternity-related indicators (e.g. % of first booking maternity appointments by 12 weeks, breast feeding initiation)	Falls for 100 bed days
	Root Cause Analysis outcomes and Serious Incident notifications	
Cancer-related indicators for all providers	Access and report turnaround time available in accordance with RCGP/RCR 2013 guidance. Waiting times: Urgent (1 week Maximum), Routine (1 week desirable, 2 week maximum). Reporting Turnaround time Next working day with 90% Tolerance.	
	Same day access and report for X-Ray diagnostics in case of high-risk lung cancer cases.	
	National Cancer Peer Review Programme (NCPR) with a compliance threshold of 75%. All cancer MDTs to be quorate with core membership present at 95% of meetings and that individual core members attend 66% of meetings.	
	For Lung cancer • A thoracic surgeon is present at all MDTs • Any abnormal CxRs with a suspicion of lung cancer are flagged to the MDT. • CT prior to first OPA - • CT scan prior to bronchoscopy 95% • Clinical nurse specialist present at diagnosis 80%	

Provider Organisation	Quality improvements Identified	Possible Stretch targets
	For breast cancer services • That an individual surgeon has a caseload of 50 per annum • That each service provides a one stop diagnostic service • That the service is delivered through the 23-hour stay model • That patients have access to immediate reconstruction That 70% of new patients are followed up through a stratified pathway of supported self-management For colorectal cancer services • All surgeons are completing the required minimum numbers of 20 cases with curative intent per annum. • Each MDT completes a minimum of 60 cases with curative intent per annum.	

Source: June performance reports, relevant guidance.

We will also be including safeguarding elements as one of the focus quality areas in our contracts for 2015/16, through the following:

- Safeguarding quarterly reports to be completed in a framework agreed with the designated nurses and adult leads.
- Reflection on learning from safeguarding team.
- Training, supervision and partnership working to be included in quarterly reports.
- Learning from case reviews and national reports.
- Detail of any specific developments.
- Annual safeguarding report.
- Quality schedule is cross referenced to these points.
- Referrals to the Local Area Designated Officer ('LADO') related to an allegation against members of the provider trust staff communicated to the commissioner within one working day of the referral.

4.2. Gaps in service delivery and improving outcomes

After reviewing the local Public Health needs assessment framework and taking account of the work that has been done to identified need through the Joint Strategic Needs Assessment ('JSNA'), we recognise that there are a number of gaps in our current provision. This will require the CCG to work closely with public health and LA colleagues as the only way of ensuring improvements is to work in collaboration with other key agencies.

We have identified the following gaps in service where we want to do further work over the coming year:

- Child health (including obesity, dental health jointly with partners) ;
- Maternity, given current provider performance on key indicators;
- Substance misuse services (joint with partner agencies);
- Preventative strategies:
    - Child and adolescent MH services;
    - Falls; and,
    - Sexual health (jointly with partner agencies).

We intend to work with WCC to develop support services for families with multiple needs to ensure consistency in provision and improved outcomes.

In addition we will strengthen the way in which the third sector is able to actively engage with and participate in health services. Therefore we will to look at ways in which it is possible to work with the third sector holistically to support whole systems integrated care and village working.

4.3. Information technology

The CCG will continue to establish information technology across its commissioned services to ensure integrated and fit for purpose solutions that link primary care with other settings of care. For the coming year the intention is to build on the established programmes. Business Intelligence is a key enabler in all aspects of the CCGs commissioning programmes and providers will be asked to align their IT offering to achieve the overarching principle of achieving one actual or virtual electronic patient record across all settings of care.

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

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

The CCG will work towards the sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care

community. Providers will be expected to actively consent patients when sharing their records.

The CCG has made considerable investment in ensuring a unified primary care IT platform. Current and future providers will be required to work within the frameworks and opportunities that a single IT system across primary care can offer. This will be translated into more granular service specifications, service improvement plans and/or CQUINs where relevant. Explicitly, the CCG will expect all staff working in community settings to use SystmOne as default clinical system and will expect providers delivering ambulatory urgent care to use SystmOne.

The overriding objective is to improve standards of care facilitated by the accurate, timely and appropriate information exchange. However, at the core will be the principle of the primacy of the primary care record and the objective to directly or indirectly achieve the outcome of one patient one integrated record.

The technology currently in place and due to be implemented during 2015-16 will bring about a turning point in how different organisations work together to provide patient centric care. The CCGs will encourage all existing and future providers to:

- Fully exploit the opportunities by the standardised and common technology platforms, engaging staff to collaboratively design and implement solutions that bring about improvements in diagnosis, treatment and longer term care.
- Implement work and information flows that will reduce the administrative and processing burden on clinical and administrative staff across different organisations.
- Ensure that information exchange is in real time, processed within native IT systems of the organisation, accurate in content, structure and coding at the point of data entry.
- Inform and enable patients to improve their understanding and access to their medical records and take a proactive role in their own care through the use of technology solutions that will improve access to their own records and interaction with care providers. In effect, enabling self-care planning tools and solutions where appropriate and particularly targeted at patients with long term conditions.

It is a key objective to enable patient access to a suite of online services as well as their own records within a robust and secure environment. Under the Prime Ministers Challenge fund programme GP practices have been and will continue to provide patients access to their online services. Providers outside of primary care will also be asked to develop or link with existing systems so that patients have greater access to wider online services and records.

The CCG will in addition focus on these areas:

- Continue working to improve the timeliness and quality of information sent to or accessible by providers from GP practices via clinical IT systems and to ensure the most up to date, relevant and accurate information is always sent.

- Continue working with providers to enable safer and more efficient electronic methods of communication between them and primary care, building on the previous work and solutions around CQUINs with a greater emphasis on structured coding and integrated workflow.
- Extending the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London. Embedding the access to pathology and radiology results across all settings of care. Ensuring that ordering tests and receiving results across NW London are exclusively done electronically with minimal manual or paper based processes.
- Within the better care fund programme work with social services to develop an interface between IT systems and more robust information exchange within common information governance frameworks. Principally that all non-healthcare providers use the NHS number as the unique identifier of the patient for all services in order to integrate records.
- Developing tools for GP clinical IT systems to provide integrated services and processes such as in common clinical templates, status alerts and searches that will highlight key patients requiring further attention. Providing a patient risk stratification tool within (rather than outside) GP clinical systems, integrating more closely with other IT systems where the patient may have a record.

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

- Choose and Book and its replacement system e-Referrals
- Ensuring high utilisation of the Electronic Prescribing System
- Close integration and information flows with Coordinate my Care system
- Maintain the high availability of accurate and timely Summary Care Record.

5. Procurement plans

The table below sets out services impacted by procurement plans initiated in 2014/15 or 2015/16.

Table 4 services impacted by procurement plans

Services where procurement is initiated in 2014/15 but there will be impact in 2015/16	*Status*	Joint commissioning	Expected Service Start date
Basic Foot Care	Contract mobilisation	With WL	Jan 2015
Diagnostics	ITT stage	NWL-wide	Oct 2015
Ophthalmology	Business case approved	With WL and HFCCG	April 2015
Expert patient programme	Business case approved	With WL and HFCCG	TBC
Respiratory and cardiology	Business case	With WL	April 2015
Dermatology	Business case	With WL	April 2015
Wheelchairs	Business case	NWL-wide	Unknown
MSK	Business case	Unilateral	Sept 2015
Community gynaecology/ urology	Business case	With WL	Sept 2015
Diabetes	Business case	Unilateral	Sept 2015
Urgent care centre at St Mary's	Scoping		TBC

Services to be procured in 2015/16	*Status*	Joint commissioning	Expected Service Start Date
NHS 111	Planning	NWL wide	Oct 2015
Gastroenterology	Planning	TBC	TBC
Podiatry	Planning	TBC	TBC
ENT	Planning	TBC	TBC
Rhematology	Planning	TBC	TBC
Out of Hours CAMHS Service	Scoping	TBC	TBC

Services to be procured in 2015/16	*Status*	Joint commissioning	Expected Service Start Date
Community Independence Service	Scoping	*With WL and HFCCG*	April 2015
Community transport	Scoping	TBC	TBC
Other interpreting services	Scoping	TBC	TBC
Other services as part of WSIC	Scoping	TBC	TBC

6. Local pathway priorities

6.1. People with a learning disability

The CCG recognises that people with a learning disability can often find it difficult to access services in a way that meets their individual needs. Work will be undertaken during the year with people with learning disabilities, their carers and other partners across the statutory and third sector to improve access to equitable healthcare. This will include primary and secondary health care, as well as keeping people safe and reducing the inequalities that people with learning disabilities face that impact on their access to effective health care.

6.2. Carers

We will continue to invest in services for carers, building on the work done in 2014/15, which has included the development of primary care based support for carers and for young carers.

As part of its Equality Objectives for 2013-2017, the CCG has committed to improving the rates of identification and support provided to carers and young carers, including within a primary care setting, and seek to offer appropriate support.

We will develop our plans in line with the intentions in the Care and Support Act, which outlines the need to provide support services to carers, rather than simply identifying their needs.

6.3. Young Carers

We will continue to maintain investment in supporting carers, with support to young carers a key priority, working closely with partners and with organisations beyond health and social care (including education) in order to continue identifying and supporting carers. This will include a family based approach to support carers and their families to improve access to health care and reduce health inequalities. We will also establish a mechanism to improve the rates of identification of young carers through primary and secondary care.

6.4. Working with the CCG membership and wider stakeholders

We will seek to strengthen the relationship between the CCG Governing Body and the member practices. This will be through further implementation of the 360 action plan, in particular:

- improving communication with member practices;
- supporting GPs to become involved in Governing Body business; and,
- improving the way that clinical quality groups undertaken their roles.

We will also aim to strengthen working arrangements with local patients and communities by continuing to build on current working arrangements with the User Panel and the wider voluntary sector organisations.

7. Summary intentions

The tables below includes a summary of Central London CCG's contracting intentions in the areas of:

a. Acute Service Reconfiguration
b. MH Transformation
c. Whole Systems Integrated Care (including Better Care Fund work streams)
d. Primary Care Transformation
e. Patient Empowerment
f. Children's Services
g. Cancer

Table 5a Summary of contracting intentions by key deliverable area (Acute Service Reconfiguration)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Acute Service Reconfiguration			
Urgent and emergency care services	**Impact of changes to Hammersmith Hospital and Central Middlesex Emergency Departments** The full year effect of the new 24/7 Urgent Care Centre ('UCC') at Hammersmith implemented in September 2014 will occur in 2015/16, including the activity transfers to other hospitals.		**Acute Trusts** (A&E and admissions flows)
	St Mary's UCC service The St Mary's UCC and Emergency Department ('ED') will be required to deliver the Shaping a Healthy Future ('SaHF') specification by 31 March 2015 as part of the wider primary care urgent care system changes and we will commission against that specification for 2015/16. This will include implementing: • 24 hour primary care leadership • Positive redirection to primary care • Discharge summaries within 24 hours • SystmOne Interoperable IT systems We intend to achieve better value for money for this service, including market testing if appropriate.		**Imperial College Healthcare NHS Trust**
	NHS 111 services The NHS 111 service is due to be re-commissioned in 2015/16 and work will commence on this in 2014/15. This service needs to integrate with the urgent care system.	Jointly with other North West London CCGs	**Current and potential service providers**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	Primary care out of hours services The GP Out of Hours service for opted-out practices is due to be re-commissioned in 2015/16. This service needs to integrate with the urgent care system.		**Current and potential service providers**
Planned care service redesign	In 2015/16, we will be mobilising services that have been procured in 2014/15: • Ophthalmology • Dermatology • Musculoskeletal ('MSK') • Cardiology/respiratory combined service • Wheelchairs • Community diagnostics Robust Communications Strategy to all stakeholders to launch new CL Planned Care Services. Service Specification development will be undertaken with local provider organisations, and aligned to Chelsea and Westminster Hospital and Imperial College Health Care Trust Out Patient O/P Clinical Transformation Plans 15/16. We will ensure that clinical reviews for supporting service redesign are aligned to the Annual Audit Plan. We will integrate a decision making tool for primary care (which may involve a procurement)	**Joint with WL CCG and HFCCG** • Ophthalmology **Joint with WL CCG** • Dermatology • Cardiology / Respiratory **Joint with North West London ('NWL') CCGs**[1] • Wheelchairs • Diagnostics	**Current and potential providers** (service delivery) New Community Incentivised Care Episode Contracts (prevention of acute admissions) to be issued. **Acute Trusts** Transfer of outpatients' appointments and outpatient procedures leading to 20-80% reduction in activity levels from acute to community setting established via commissioning round 2015/16. ***(£3.4m of cardiology and respiratory outpatient services to be decommissioned from existing acute and community providers; £450k of ophthalmology outpatient services to be decommissioned from existing acute providers.***) **Community providers** Current providers of community MSK, Diabetes, Dermatology, Cardio and Respiratory Rehabilitation will also be affected in 2015/16 by change of provider. .

[1] NHS North West London Collaborative of Clinical Commissioning Groups are a collaboration of NHS Brent CCG, NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith & Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG, and NHS West London CCG.

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
			Proposed Key Performance Indicators/CQUINS • Community providers: Accountability for GP Education • Acute providers: Follow-up appointments transfer into community Primary care: Undertaking GP Education.
	In 2015/16, we will be reviewing and redesigning following services, with associated procurements: • Gastroenterology, • Podiatry • Ear, Nose & Throat ('ENT') • Rheumatology • Diabetes • High Cost Drugs (Ophthalmology) • Gynaecology/urology combined service.	**Joint with WL CCG** • Gynaecology/ Urology	Currently there is no ENT, Gastroenterology or Rheumatology Services in the community. The ambition is to move a minimum of 30% of acute activity in this setting. Rheumatology and Gastroenterology (Upper Gastro-Intestinal) are in the upper quartile of acute overspends, regarding prescribing costs. The ambition is to reduce prescribing spend by a minimum of 15% for these service areas. Diabetes,
End of life care services	A strategic review of end of life care provision is to be completed in 2014/15; this is expected to have key recommendations for increasing the number of people able to die in the place of their choosing and making greater use of care planning by reducing the number of A&E visits and emergency admissions in the last year of life.	Jointly with LA	**Community palliative, hospice care services, and bereavement, ambulance and primary care services** (service delivery) **Acute Trusts** (admissions and A&E avoidance, LoS reductions)
Improve care home provision	As part of our review of care home provision in 2014/15, we will be reviewing demand and capacity and making recommendations for implementation commencing in 2015/16. This will include using intelligence about the quality of placements and safeguarding arrangements. We will also agree the refurbishment and refit phase	Jointly with LA	**Care home providers** (service delivery)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	of SHOSP programme in 2014/15 for implementation in 2015/16. In 2015/16 through the BCF we will integrate the contracting and brokerage functions for Nursing and Residential Care placements across adult social care and health, creating a single team. Under this arrangement CCGs will continue to have governance for health-funded placements and the local authority will continue to have governance for adult social care placements. We will work jointly to shape the provider market, to optimise the quality and value of placements and to support its development to align with our strategic direction.		

Table 5b Summary of contracting intentions by key deliverable area (Mental Health Transformation)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Mental Health Transformation			
Dementia services	Additional Dementia diagnosis services have been commissioned in 2014/15 from non-recurrent funds. This second half of this contract will be delivered in 2015/16. In addition, the North West London Mental Health Programme Board is undertaking a review of dementia services; this review will be reporting later in 2014/15 and in 2015/16 we will be implementing the recommendations. These are likely to include creating a pathway which: • Increases capability to diagnose dementia in primary care. • Increases specialisation of secondary care services to cover complex diagnosis. • Increases the scope of practitioners working at the primary/secondary interface. • Strengthened post-diagnosis support services including advocacy and advice service. We will commission services in line with the outcomes of this review.		**Primary care, MH Trusts & Third sector** (service delivery)
Increasing Access to Psychological therapies	NHS England's Operating Plan in 2014/15 mandates psychological therapies capacity at 15% of the Common Mental Illness prevalence to be provided by all CCGs in 2015/16. Central London CCG has commissioned additional capacity to meet this requirement as an interim measure, potentially until the end of 2015/16, while work is underway to review and benchmark provision across NWL. The recommendations of this review are expected later in 2014/15 and will be implemented in 2015/16. This is likely to include procurement to increase the diversity of provision and extend services to include young people, long-term conditions, Medically Unexplained Symptoms ('MUS') and severe and enduring MH problems.		**CNWL, Third sector providers and Primary Care** (service delivery) **CNWL Trust** (admissions avoidance through early intervention)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Shifting Settings of Care	Building on the Primary Care Plus Mental Health Service ('PCP') which is established in Central London, we will review the specification for the current service in order to increase the transfer of services out of secondary community MH to primary care to support people in their homes. This will include: • Strengthening the capability of referral management and signposting services for routine services through the non-urgent single point of access. • Reviewing the model of care for stepping down patients from secondary community care services and achieving the ambitions of Shaping Healthier Lives. This may also include a competitive tendering process depending on the progress made with the current service. We will also seek to repatriate out of area activity to local providers reducing spot-purchase costs.		**CNWL and third sector providers** (service delivery) **CNWL** (admissions avoidance and LOS reduction for MH) Based on work being completed in 2014/15, we will set the number of step downs to be achieved using the RAG-rated recovery caseload with the expectation that all appropriate green-rated patients are stepped down, and all amber-rated patients have a plan. **Out of area placement providers** through MH trust efficiency
Urgent care services	Building on the parity of esteem agenda, and in response to the Crisis Concordat 2014, we will work with providers to implement a value-for-money, 24/7 single point of access to urgent and emergency MH services. This will provide rapid access to appropriate service, including crisis response, Assessment and Brief Treatment, home treatment and signposting to relevant services. We will contract with providers to ensure treatment of MH emergencies has the same importance as a physical health emergency. We will review services to reduce the likelihood of future crisis through multi-agency recovery focused		**CNWL, primary care and Third sector** (service delivery) **CNWL Trust** (admissions avoidance)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	post crisis support. During 2015-2016, commissioners will contract with providers to: • Implement expediently any remaining performance improvement to deliver the NWL MH access standards for achievement by end of Quarter 1 (where necessary). • Contract for a quality improvement trajectory in terms of key Shared Care communication paperwork (MH2 – MH5.3, including those specifically tested under the Urgent Care and Access CQUIN: MH3, MH5.1 and MH5.3), for achievement by end of Quarter1 (where necessary). • Ensure that the needs of a range of currently under-served groups are met, such as the needs of those in transition from CAMHS, those with Personality Disorder and those with severe behavioural disorders. • Address workforce development by delivering relevant training to support clinical pathways and develop core skills and competencies to enable the CCG to deliver high quality services. Utilise developments in electronic e-referral systems and 'intelligence sharing' to enable trusted assessment across teams, improved access to treatment, faster response times and 'improved local health record self -ownership'.		
Parental mental health services	We will implement the recommendations of the Health and Wellbeing Board Children and Young People's Mental Health Working Group regarding Parental Mental Health by improving the resources available in the community for parental mental health.		**Various providers**
Perinatal mental health service	We will commission services based on the recommendations of the review that is being undertaken in 2014/15. This is likely to include: • Services for all women who may experience a common mental illness (anxiety and depression) during pregnancy as well as those with a known MH problem or those who develop severe mental illness, which can be accessed to perinatal MH services for GPs and community		**CNWL and third sector providers**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	health professionals. • Specialist perinatal services for all women with MH needs, incorporating MH midwives, and specialist MH nurses working with community midwifery teams and health visitors. • GPs to have access to a service to get specialist advice from and refer when required. • Commission third sector involvement to support families.		
Continued implementation of psychiatric liaison standards	Specifically, in 2015/16, commissioners will be seeking to: • Secure full roll out of, and reporting against, the developmental measures being piloted by CNWL under the 2014-15 quality dashboard relating to patient experience, clinical outcomes and referrer experience. • Achieve greater core standardisation of services across all sites in terms of workforce skills mix, costs, activity, impact and productivity in line with contractual requirements. • Obtain further commissioning and delivery clarity on the nature of services across sites and, where there is a significant on-going psychological therapy provided for those with Long Term Conditions, ensure synergy with IAPT commissioning and delivery. We will require providers to work with us to understand the impact of changes in urgent care and IAPT current provision on Psychiatric Liaison Services		**CNWL** (service delivery)
Suicide prevention	We will continue to lead on implementing the Tri-Borough CCGs' Suicide Prevention Strategy 2013-18. In 2015/16 we will commission a suicide awareness and intervention training programme for multi-sector providers.	HFCCG, WL CCG, Public Health	**Potential providers**

Table 5c Summary of contracting intentions by key deliverable area (Whole Systems Integrated Care)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Whole Systems Integrated Care (including Better Care Fund work streams)			
New models of care in place for early adopters	**Capitated budgets and system management** Shadow capitation budgets will be in place and monitored for identified patient cohort, to enable the management of the new care model through the Whole Systems Integrated Care ('WSIC') provider network.	Westminster City Council ('WCC')	**Acute, community, mental health and primary care providers**
	Improving provision for people with long term conditions Through the WSIC model, we will support patients who are diagnosed with a long term condition through education and information to manage their condition and stay well.		**WSIC provider network** (service delivery) **Acute Trusts** (admissions and Accident and Emergency – A&E – avoidance, Length of Stay – 'LoS'- reductions)
	Improve care plan delivery and coordination Using a shared, single system, we will deliver care plans for those that need them in conjunction with care professionals, patients and care co-ordinators. The current care planning service Wellwatch, and Patient Referral Service, both delivered by Central London will be decommissioned and replaced by care planning and coordination within the Whole Systems Integrated Care model of care.		
	Improve care for vulnerable elderly We will commission greater geriatrician input into villages[2], including developing our falls prevention service.		
	Strengthening primary care services We will support the development of primary care through integration and alignment with other key services to strengthen provision and resilience.		**GP practices and GP provider network** (service delivery)
	Improve patient wellbeing We will implement a methodology for measuring and monitoring self-reported wellbeing using patients' life priorities in their care plans.		**WSIC provider network** (service delivery)

[2] Sub-localities.

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Implement new Community Independence Service model	A set out in section 3.5. above, a process will be run between existing providers in order to appoint a lead health provider to work in partnership with a lead local authority partner to ensure delivery of a single integrated service. Starting in quarter 3 of 2014/15 commissioners, the process will be completed by 1st April 2015 in preparation for the transition year. The process will be designed to secure the collaborative agreement across all providers to implement the necessary changes that deliver the outcomes specified under the new service model. The lead provider (s) will need to demonstrate how they will ensure: • A rapid response multidisciplinary team (MDT) providing community care within 2 hours and for up to 5 days • Non-bedded community rehabilitation, treating non-complex conditions in a community setting. • Integrated reablement with access to short term community beds between 6 and 12 weeks. • 7 day support to help people leave hospital.	Hammersmith & Fulham CCG ('HFCCG') West London CCG ('WLCCG') WCC Royal Borough of Chelsea & Kensington ('RBKC') London Borough of Hammersmith & Fulham ('LBHF')	**Central London Community Healthcare ('CLCH') and WCC** (service delivery) **Acute Trusts** (admissions and A&E avoidance, LoS reductions ***c.£1.3m NEL and £16 k A&E decommissioned across all providers***) **Residential and care homes** (placement avoidance and LoS reduction)
Improve services for the homeless	**Service integration** We will continue to work with providers to ensure that physical and MH services for the homeless are fully integrated.		**Acute. MH and Community Trusts**
	Intermediate Care services Building on the work done to pilot intermediate care services for the homeless in 2014/15, we will commission a targeted intermediate care facility linked to local hostel provision to support patients discharged from hospital and reduce admission to hospital.		**Current and potential providers** (service delivery) **Acute and MH services** (admissions and A&E avoidance)
	Other services We will continue to commission the Hepatitis C clinic started in 2014/15 for the second year of the pilot. We will continue to commission support services for the homeless through		**Primary care** (service delivery)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	Groundswell. We will consider commissioning addition services for Tuberculosis in primary care**.**		
Extend the provision of neuro-rehabilitation and intermediate care beds	Benchmarking and a Tri-borough needs analysis has been undertaken for intermediate care in 2014. This indicates that an increase in step up intermediate care beds including neuro-rehabilitation bedded capacity is likely to be needed across the Tri-borough in order to meet the national average and deliver sustainable provision. We will complete the necessary detailed work to progress this and understand fully the implications in terms of dedicated medical support, enhanced nursing care provision and quick access to diagnostics, as well as financial and activity modelling to underpin future requirements.	Joint with HFCCG and the Tri-borough LA	**Acute, community and social care providers**
Explore extending the provision of intermediate care beds	The benchmarking and needs analysis work undertaken for intermediate care services in 2014/15 indicates that additional intermediate care beds could be required across the Tri-borough in order to meet the national average and deliver sustainable provision. With this in mind, we will explore extending the provision of step up intermediate care beds across the Tri-borough to avoid preventable hospital admissions. If the CCG decides to commission this service it will require dedicated medical support, enhanced nursing care provision and quick access to diagnostics to support people with exacerbated long-term conditions.	Joint with HFCCG and the Tri-borough LA	**Acute, community and social care providers** (extended service delivery)
Making Every Contact Count	We will work with providers to support them to proactively identify and take opportunities to have brief, purposeful conversations with patients and their families/carers about health and wellbeing issues outside the primary purpose of the contact. This includes helping them resolve their ambivalence to change and providing information and signposting to services on lifestyle issues (e.g. physical activity, smoking, diet) as well as wider determinants (e.g. housing conditions, social isolation, childhood poverty)	WCC	Current and potential providers

Table 5d Summary of contracting intentions by key deliverable area (Primary Care Transformation)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Primary Care Transformation			
Deliver population-wide access to Out of Hospital services in general practice	The CCGs in the CWHHE collaborative are working together to enable transformation within primary care. The CCGs have agreed to realign services to support the delivery of the Out of Hospital strategies, including the commissioning of a consistent range of services – an Out of Hospital services portfolio - from GP federation(s). In 2015/16, the roll-out of the service portfolio will be completed with the aim to have full population coverage by 2016/17. Further details are provided in Section 6. This will result in shifts of activity out of hospital for: • A&E and Urgent Care Centre attendances • Wound care service (simple and complex) • Diabetes and endocrinology outpatients • Gynaecology outpatient procedures • ECG diagnostic testing • Ambulatory Blood Pressure Monitoring • Respiratory diagnostic services • Mental health services for complex common and severe and enduring conditions		**GP provider network** (service delivery) **Acute, Mental Health and Community Services** (activity moved to primary care settings) ***(expected decommissioning of services across all acute providers amounting to £3.5m based on latest business case)***
Deliver Prime Minister's Challenge Fund objectives	As described in section 3.3, we will work with our GP provider network to implement: • 7 day primary care services operating within federation(s) • A range of consultation methods to be available to practices (telephone/email/Skype); this includes the evaluation of the Skype pilot we have undertaken in 2014/15.		**Primary care** (service delivery) **Acute Trusts** (reduced demand)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	• Alternative appointment booking methods to be available in primary care (e.g. online booking). • Patients being able to access their records online. • Increased capacity and evenings and weekends.		
Improving medication compliance	We will continue to work closely with our prescribers to: • Ensure that patients on multiple medications have regular reviews. • Ensure that those patients whose clinical outcomes do not match their medications are reviewed. • Use hybrid workers to ensure patients are taking medications effectively. • Ensure that patients' medications are reviewed following an inpatient stay.		**Primary care** (Service delivery)
Improve services for people with suspected Deep Vein Thrombosis ('DVT')	We will evaluate the pilot for testing patients in primary care with suspected DVT as part of a revised DVT pathway involving acute ambulatory care. We will consider wider roll out and implementation within primary care as an additional Out of Hospital Services Contract		**Primary care and ChelWest Hospital and Imperial College Healthcare Trust** (Service delivery) **Acute Trusts** (admissions and A&E avoidance)
Better understanding of services available within villages	Implement the findings of the village needs assessment programme to strengthen use of local services.		**Various, especially Third sector**

Table 5e Summary of contracting intentions by key deliverable area (Patient Empowerment)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Patient Empowerment			
Increase use of personal health budgets	Working with the local authorities we will expand the patient/customer groups who are offered personal health budgets ('PHB'). Personal health budgets offer an opportunity to engage people in their support planning, their health outcomes and the choice of health services to meet those outcomes. We aim to increase the ways in which people with significant health needs can shape their own care, take more control, have more choice and increase person-centred care. These actions within our principles of market development and integrated personal commissioning. Areas of focus are. • **Personal health budgets for people with Continuing Healthcare** ('CHC'). We will continue to offer these to everyone who is eligible of CHC in all care groups. Everyone who is CHC eligible is currently offered the opportunity for a personal health budget (notional, managed or through direct payments). • **Mental Health Personal Health Budgets**: We will complete the mental health pilot with WLCCG and Kensington and Chelsea MIND and in line with (awaiting) 2015 guidance on personal health budgets and mental health, we will make these available for certain groups, by working with the independent sector as key designing partner. • **Long Term Conditions Personal Health Budgets**: Personal health budgets will be offered to people with a range of Long Term Conditions. We will undertake a pilot for LTC and publish our offer from April 2015, as well as challenge our existing service provision by reviewing all relevant contracts to determine areas which are 'cashable' and can be used to provide services in a different way. This may be through 'top slicing' a small percentage of contract value in order to use the money differently. • **Children's Personal Health Budgets:** We will continue to work with our Local Authority partners to implement the Children and Family Act 2014 and in particular, new undertakings in relation to personal health budgets. This will include signposting eligible children, young people and families and ensuring personal health budgets are considered as part of the Continuing Healthcare plans. We will also ensure the transition from children's services to adult services works seamlessly for those who have personal health budgets, as part of their support plans.	Joint with LA	**Various**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Self-management through the Better Care Fund ('BCF')	Strengthen the choices available to patients.	Joint with LA	**Various**
A strong expert patient service	We will be mobilising a new Expert Patient Service for patients, including an on-line version, which is being procured in 2014/15.	HFCCG and WL CCG	**DESTA (Current provider) and potential providers**
Improve patient transport	Based on finding of the community transport survey and service review being undertaken in 2014/15, we will make adjustments as necessary to the delivery model, which may involve procuring a new patient transport service or using existing framework agreements.		**Current and potential providers**
Improving understanding and knowledge of patient experience	We will contract to improve the quarterly submission by providers of patient experience reports to ensure that they include complaint themes, survey results and friends and family results and the actions being taken to deliver improvements We will also continue to support GP practices to establish and maintain Patient Participation Groups.		**All Trusts** **GP practices**
Improving patient and carer experience across health and social care for people	We will establish and embed processes to enable people with a learning disability to engage with existing engagement routes by making them fully accessible, or provide a forum for people with learning disabilities to be fully engaged in developing and improving access to mainstream health services and reducing health inequalities. Establish an accessible process/mechanism to enable people with a learning disability to provide feedback on their experience of services.	Joint with LA	**Various**

Table 5f Summary of contracting intentions by key deliverable area (Children's services)

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
Children's Services			
CAMHS services	Based on the findings of the National Review of CAMHS, the local review of CAMHS being undertaken in 2014/15 through the Health and Wellbeing Board Children and Young People's Mental Health Working Group, and the review of CAMHS out of hours services, we will redesign and/or commission a number of services. • A Tri-Borough behavioural support team for CAMHS Learning Disabilities ('LD'). • Improved front door – consultation and advice service and more efficient and effective access to CAMHS. • A streamlined Tri-borough looked after Children CAMHS. • An improved 24/7 crisis response services by integrating out of hours services with mainstream provision. • Training and public education programme with Public health and potentially safeguarding boards Tri-borough. We will work with NHS England ('NHSE') to ensure good pathways into and out of CAMHS tier 4. We will ensure CAMHS Improving Access to Psychological Therapies ('IAPT') is at the centre of commissioning and outcome measurements.	Joint with the LA	**MH Trusts**
Improving children and young peoples' services in villages	We will evaluate the 2014/15 pilot and consider a wider service in line with Connecting Care for Children; this will involve increasing the number of children's clinics and multidisciplinary team meetings in primary care settings. We will work jointly with our LA partners when considering re-staging of these services in the community to achieve maximum efficiencies and co-location of services for children and families.	Joint with LA	**Primary Care and Acute Trusts** (multi-disciplinary service delivery)
Tackling childhood	Working with Public Health we will review current obesity services	Joint with LA	**All**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
obesity	provision design and commence implementation of new obesity pathways to direct those at most risk to interventions aimed at reducing childhood obesity.		
Improve outcomes for mothers and babies	We will review current provision jointly with LA and NHS England and implement changes that will improve the services provided and implement the recommendations from SaHF in relation to maternity care including: • Consolidation of maternity and neonatal services from seven to six sites to provide comprehensive obstetric and midwife-led delivery care and neonatal care. • Consolidation of paediatric inpatient services from six sites to five sites to incorporate paediatric emergency care, inpatients and short stay /ambulatory facilities. To support the delivery of this transition a central booking system will be implemented to co-ordinate the booking process across the receiving sites	Joint with LA and NHS England	**Acute Trusts (Chelsea and Westminster, Hillingdon, Northwest London Hospital Trust, Imperial and West Middlesex)**
Speech and Language	Westminster Speech and Language Provision was reviewed in 2013-14. Upward pressure on demand was recognised and in line with recommended best practice, a Tri-Borough Joint Commissioning Group was established with local authority partners. The joint Commissioning Group is now developing a re-procurement plan for 2015-16 and detailed project proposals will be drawn up once NWL CCG procurement input has been secured.		**Current providers**
Children's and Families Act 2014 (including personal health budgets)	We will implement changes required as a consequence of the Act. These include: • Signposting families to the LA 'local offer' website which summarises Education, Health and Care service available for young people with Special Educational Needs ('SEN') and disabilities		**Various**

Key deliverable area	Contracting intention	Joint commissioners	Expected provider impacts (financial and activity, when known)
	• Continue to commissioning local child development services to provide timely health assessments for Education, Health & Care Plans. • Collaborating with our LA partners to deliver 'personal health budgets' and 'joint commissioned' services for young people with SEN and disability needs.		
Improve transition services for 15-17 year olds	Jointly with LA, we will review current provision for this group of patients. Based on the findings of this review we will seek to lessen the impact of moving from paediatric to adult services; this is likely to be by commissioning specific services for adolescents or by changing the traditional age boundaries associated with particular services.	Jointly with LA	Acute, Mental Health and Community Trusts
School nursing services	We are considering commissioning additional special school nursing services to meet the complex health needs of children attending.	Jointly with LA/ public health	
Health visiting	We will work closely with Public Health and LA colleagues to secure effective transition of the service from NHSE.	Jointly with LA/ public health	

Table 5g. Summary of contracting intentions by key deliverable area (Cancer Services)

Key deliverable area	Contracting intention	Joint Commissioners	Expected provider impacts (financial and activity, when known)
Access to Diagnostic services	All GPs to have direct access to: • **colonoscopy** for low risk, not no risk of cancer via a diagnostic service; • **flexible sigmoidoscopy** for low risk, not no risk of cancer; • **non-obstetric ultrasound** for low risk, not no risk of cancer; and, • same day **chest x-ray for high risk of cancer** and access for low risk, not no risk of cancer.		**Current and potential providers**
	In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support US and CA125 concurrently.		**Current and potential providers**
	In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent care Centres and inpatient chest X-rays ('CxR').		**Current and potential providers**
Robust treatment decision-making	All commissioned cancer services will participate in the National Cancer Peer Review Programme ('NCPR') or other quality assurance programme as defined by commissioners.		**Current and potential providers**
	All cancer services commissioned will be required to demonstrate robust treatment decision making through MDT.		**Current and potential providers**
Robust service specification	Robust service specification for cancer services: • All lung cancer services will be commissioned in line with best practice through a timed pathway. • Endobronchial US ('EBUS') services are commissioned to an agreed service specification and tariff. • All breast cancer services will be commissioned in line with best practice through a timed pathway and follow up in line with the National cancer survivorship initiative ('NCSI'). • All services for prostate cancer will be commissioned in line with NICE guidance through a timed pathway with follow up in line with the NCSI. • All services for colorectal cancer ('CRC') will be commissioned in line with NICE guidance through a timed pathway with follow up in line with the NCSI.		**Current and potential providers**

Key deliverable area	Contracting intention	Joint Commissioners	Expected provider impacts (financial and activity, when known)
Cancer as a long term condition	Agree and implement service consolidation plans – providers will work with their Integrated Cancer System ('ICS') and commissioners to implement the cancer Model of Care		**Current and potential providers**
	All cancer services will be commissioned to deliver the recovery package as described in the NCSI. • For Breast Cancer- 70% of new patients are followed up through a stratified pathway of supported self-management. • For Colorectal cancer – 40%of new patients are followed up through a stratified pathway of supported self-management. • For Prostate Cancer-40%of new patients are followed up through a stratified pathway of supported self-management.		**Current and potential providers**
Appropriate management of the late effects of anti-cancer treatment	Services will be commissioned to manage some of the consequences of anti-cancer treatment as below. • Services for the management of gastro-intestinal ('GI') late effects: All Multi-disciplinary teams ('MDT') that use pelvic Radiotherapy ('RT') will have agreed pathways in place for the management of GI late effects. • Services for lymphedema: All MDTs where treatments may result in lymphoedema have agreed pathways in place to access services including exercise as per NICE guidance. • Services for psychological and physical sexual related problems: All MDTs where treatments may result in sexual function problems both male and female have clear referral pathways in place for management.		**Current and potential providers**
Contracting of additional cancer services	Services will be commissioned to provide pathways for the management of treatment related fertility issues.		**Current and potential providers**
	Services will be commissioned for the management of those with a family history of moderate risk breast cancer to a Pan London specification.		**Current and potential providers**
	Services for the provision of Metastatic Spinal Cord Compression ('MSCC') will be commissioned in line with NICE QS56.		**Current and potential providers**

8. Equality impacts

8.1 Duty to Involve

Our CCG is mindful of its individual participation duty to ensure that we commission services which promote the involvement of patients across the full spectrum of prevention or diagnosis, care planning, treatment and care management when discharging its duty. We have been working in partnership with patients, carers, the wider public and local partners to ensure that commissioned services are responsive to the needs of our population.

Our Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders to identify the key priority areas. It requires commissioned providers to ensure that patients, service users and carers are provided with opportunities to get involved in shaping and influencing services and the organisations as a whole.

We therefore expect providers to evidence their engagement with service users and carers in the planning, development and delivery of their services. More specifically, we expect providers to:

- Train and support service users and carers to be effectively engaged in the design and delivery of services as well as in shaping and influencing the organisation as a whole.
- Work with local voluntary organisations and patient groups to deliver a programme of staff training and capacity development in order to understand the experience of specific groups and communities.
- Ensure that any feedback about their services reflects the diversity of the patient and service user population.
- Work in partnership with local health and social care organisations to capture experiences relating to integrated care.

8.2 Promoting Equalities and Improving Patient Experience and Access

We expect providers to measure patients, service user and carers experience of access to services and demonstrate that commissioned services are accessible by all. This will be evidenced by:

- Patient experience. Information to include data relating to key equality groups. More specifically, data should be recorded in line with the categories and sub-categories as defined by the Office of National Statistics ('ONS') in order to reflect the diversity of the local population. In addition, the data should be assessed to establish if:
    - There are differences in the outcomes experienced by patients, service users and carers;

  - There are differences in the perception of treatment and care between patients, service users and carers from different equality groups; and,
  - Action has taken place to address gaps in relation to points 1 and 2.

- Uptake and Use of services. To assess whether:
  - There are differences in the frequency of usage by different equalities groups e.g. A&E and UCCs;
  - The services are being delivered to meet the needs of the diverse population;
  - There is anything further the service can do to increase usage by those groups of patients that currently under-use the service; and,
  - Action has taken place to address gaps in relation to points 1, 2 and 3.

- Complaints and other feedback. To assess whether:
  - There are any differences in the rate of complaints from different groups with different needs or circumstances;
  - There are particular aspects of the service that cause problems for particular groups of patients, service users and carers;
  - There are an underlying causes or barriers that mean that certain groups are receiving a better service than others;
  - Different groups have varying expectations of the service; and,
  - Equalities monitoring is carried out for investigated complaints on a sample basis by the Complaints Team and reported on quarterly basis.

- Children with disabilities. To ensure that providers have in place a range of facilities and support available to children with disabilities and their carers, specifically:
  - Waiting areas that are sensitive to the needs of disabled children;
  - Changing Places / Toilets for children with complex needs, equipped with the right equipment and enough space;
  - Facilities for complex needs children admitted to hospital wards provide adequate hoists and changing facilities, as well as suitable food and nutrition e.g. pureed food;
  - Signposting to support groups;
  - Offering coping strategies at the point of diagnosis; and,
  - That parents and GPs are copied in on all doctors and therapist reports.

8.3. Engaging with stakeholders

Our contracting intentions are based on on going engagement around our strategic plans. A high-level impact assessment of our contracting intentions, measured against our Equality Objectives for 2013-16, is set out below.

- *Goal 1: Better health outcomes for all.* Our contracting intentions set out a broad programme of work which we believe fully encompasses the general themes of our action plan.

- *Goal 2: Improved patient access and experience.* Areas of delivery around increased access to psychological therapies, population-wide access to out of hospital services in general practice and seven-day primary care services. During 2015/16 we will continue work to improve our understanding and knowledge of patient experience through better provider patient experience reports.
- *Goal 3: Empowered, engaged and well supported staff*. As the CSU is reincorporated into the CCG, we will be undertake a review of our new workforce to effectively assess the development needs of our staff, particularly those with caring responsibilities, those with disabilities and those from Black, Asian and Minority Communities.
- *Goal 4: Inclusive leadership at all levels.* The Equalities Reference Group across the CWHHE Collaborative will continue to report to our relevant Governing Body Committee, ensuring we deliver on our equality objectives. We will also undertake further work during 2015/16 to strengthen our current governance structures.

We have gathered feedback from our user panel and received a number of comments and requests for clarification. The comments we received related to:

- Our mandate from NHSE to procure local 111 services in 2015/16;

- Activities we undertake to keep dementia at bay, such as our memory café, and art and signing classes. We have also recently approved the utilisation of dormant funding for a dementia out-reach service to be provided by CNWL.

- The support available to patients with communication difficulties, which covers all communication barriers (including limited knowledge of the English language, learning disabilities, visual and/or hearing impairment);

- Our work with our IAPT providers on how we can increase access to psychological therapies to our minority populations (e.g. Black, Asian and Minority Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups; Deaf or hard of hearing, young people, foreign language speakers, and people with long term conditions);

- Our plans to define and deliver mental health education training to key partners, e.g. GPs and practice staff;

- What we are doing to reduce gaps in transition from CAMHs to Adult services, reflecting different thresholds by evaluating discharge work into primary care and protocols of transition for those going to Adult services; and,

- How we are working with our mental health secondary care provider to improve the efficiency of bed availability in order to reduce the cost of purchasing beds elsewhere (‘spot purchase costs’).

Appendix 1 Glossary

Acronym	Term
A&E	Accident & Emergency
ABPM	Ambulatory Blood Pressure Monitoring
ACP	Accountable Care Partnership
AMU	Acute Medical Unit
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
ChelWest	Chelsea and Westminster Hospital NHS Foundation Trust
CI	Commissioning Intention
CLCCG	Central London Clinical Commissioning Group
CLCH	Central London Community Healthcare
CRC	Colorectal Cancer
CT	Computerised Tomography
CxR	Chest X-Rays
DVT	Deep Vein Thrombosis
EBUS	Endobronchial Ultrasound
ECG	Electrocardiogram
ED	Emergency Department
ENT	Ear, Nose and Throat
FYE	Full Year Effect
GI	Gastrointestinal
GMS	General Medical Services
GP	General Practitioner
GSTT	Guy's and St Thomas' Hospital NHS Foundation Trust
HENWL	Health Education North West London
HFCCG	Hammersmith and Fulham Clinical Commissioning Group
HIV	Human Immunodeficiency Virus
IAPT	Improving Access to Psychological Therapies
ImBC	Implementation Business Case
ICHT	Imperial College Healthcare Trust
ICS	Integrated Cancer System
ICU	Intensive Care Unit
IRP	Independent Reconfiguration Panel
IT	Information Technology

Acronym	Term
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LA	Local Authority
LADO	Local Area Designated Officer
LBHF	London Borough of Hammersmith and Fulham
LD	Learning Disabilities
LGBT	Lesbian, Gay, Bisexual and Transgender
LoS	Length of Stay
LTC	Long Term Condition
MDT	Multidisciplinary Team
MH	Mental Health
MRI	Magnetic Resonance Imaging
MSCC	Metastatic Spinal Cord Compression
MSK	Musculoskeletal
MUS	Medically Unexplained Symptoms
NAS	National Autistic Society
NCPR	National Cancer Peer Review Programme
NCSI	National Cancer Survivorship Initiative
NEL	Non-Elective Admissions
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NWL	North West London
OBC	Outline Business Case
ONS	Office for National Statistics
OOHS	Out of Hospital Services
OPA	Outpatient Appointment
p.a.	Per annum
PCCJC	Primary Care Co-Commissioning Joint Committee
PCP	Primary Care Plus Mental Health Service
PHB	Personal Health Budget
PMCF	Prime Minister's Challenge Fund
PPG	Patient Participation Group
PRS	Patient Referral Service
QIPP	Quality Innovation Productivity Prevention
RBKC	Royal Borough of Kensington and Chelsea
RCGP	Royal College of General Practitioners
RCR	Royal College of Radiologists
RT	Radiotherapy
SAU	Surgical Assessment Unit

Acronym	Term
SEN	Special Educational Needs
SaHF	Shaping a Healthy Future
SHSOP	Specialist Housing Strategy for Older People
SPA	Single Point of Access
TB	Tuberculosis
UCC	Urgent Care Centre
UCLH	University College London Hospitals NHS Foundation Trust
US	Ultrasound
VANA	Village Asset Needs Assessment
WCC	Westminster City Council
WLCCG	West London Clinical Commissioning Group
WSIC	Whole Systems Integrated Care