NHS
Richmond
Clinical Commissioning Group

Richmond Clinical Commissioning Group Commissioning Intentions 2016/17

Our Corporate Objectives:

1. We will use the experience of GPs and other healthcare professionals to commission safe, efficient, sustainable secondary, tertiary and community health services
2. We will work closely with our local health providers in primary, social and community care, the local authority, and community and voluntary sectors to secure the best services delivered in the best setting for local people
3. We will engage and involve the local population in the decisions we make in the planning, design, procurement and quality monitoring of services and ensure sustained focus on improving quality and safety of services
4. We will ensure appropriate constitutional and governance arrangements are in place to enable the CCG to become a highly effective membership organisation
5. We will ensure the most efficient use of resources to get the best value for patients

Foreword

Dr Graham Lewis – Chair, NHS Richmond Clinical Commissioning Group (CCG)
Graham Lewis is a partner at Hampton Medical Centre. He qualified from Leeds University and trained as a GP in Croydon. He has worked as a GP in Richmond since 1983.

NHS Richmond Clinical Commissioning Group's (CCG) primary purpose is to improve the health and wellbeing of the residents of the borough of Richmond, by commissioning a range of high quality, effective and value for money services from community to acute hospital settings, enabling the residents of Richmond to be as healthy as they can be.

We are committed to ensuring that Richmond CCG delivers on its five promises for the residents of Richmond and we undertake to support and work closely with primary, community and secondary care colleagues to deliver them.

The borough of Richmond is generally a healthy and safe borough. However, we do have our own challenges to face which include;

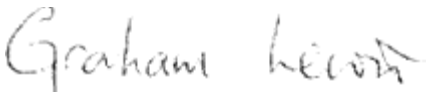
- an ageing population with a significant number of older people living alone
- an increasing number of people living with one or more long term medical conditions
- a rising number of patients with dementia related health problems;
- challenges in weight management in both adults and children;
- increasing emotional, self-esteem and wellbeing issues in our school age population;

all of which create increasing demands on our hospitals, primary and community services. Data indicates we are not yet achieving the required levels of childhood immunisations needed to protect all local children and young people from serious diseases such as measles.

We face these challenges in a financially constrained environment, where the anticipated funding gap for the NHS in 2020 is likely to be around £30bn nationally. Therefore, Richmond CCG needs to make some bold changes. Changes to how we as a commissioning organisation manage these challenges and in the way we work with our partners, the providers of services. Changes in how those services are delivered as effectively, efficiently and seamlessly as possible in order to stay ahead of the health and financial challenges facing the local health economy.

To achieve this, we are committed to the development of integrated services at every level of Richmond's health economy. Services will be designed and delivered around the needs of the patient, integrating the patient pathways in physical and mental health, in health and social care and between our primary, community, secondary and voluntary care services. We will also identify areas where desired outcomes are common between CCGs, in order to work with others to achieve economies of scale. In essence, we have to remove perceived barriers through integration between organisations and services.

As a clinically-led organisation, we will make sure the services we commission have a strong clinical focus to guarantee patient safety and quality. We will do this by using information that patients provide to local GP practices and other clinical colleagues about their experience of the services the CCG commissions. The CCG will use this information to continue to improve the quality of care our residents receive.



Dr Graham Lewis

1. Introduction

Richmond CCG has developed/ is developing a number of key strategic plans which combined set out our commissioning intentions for 2016/17. These plans come in response to a number of national policies including the NHS five year forward view and the Better Care Fund guidance. The plans we have drawn on to develop our commissioning intentions include:

- Joint Strategic Needs Assessment
- CCG 2 year Operating Plan (2014-16)
- CCG operating plan 2015/16
- Quality, Innovation, Productivity and Prevention plan
- Better Care Fund Plan
- System Resilience Plan
- Outcomes Based Commissioning plan
- Prime Ministers Challenge Fund bid
- South West London Primary Care Co-commissioning plan
- South West London Commissioning Intentions (see appendices)
- Health London Partnership Commissioning Intentions (see appendices)
- Cancer Strategy
- Prevention Strategy
- Joint Better Care Closer to Home Strategy
- Joint Children and Young People's Plan
- Joint Older People and Adult Mental Health Strategies.
- Joint Carers Strategy
- Richmond Health and Wellbeing Strategy

Commissioning intentions set out the strategic context in which Richmond CCG is operating and describe the key changes we intend to pursue with providers for 2016/17 to enable us to respond to the challenges we face and support the delivery of our financial, quality and performance objectives.

2. Case for Change

The NHS five year forward view sets out the case for the change that is needed within the NHS in order to narrow three key gaps:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

The vision for the future of the NHS is one that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

Richmond CCG submitted its Better Care Fund Plan in September 2014, Operating Plan in May 2015 and is developing its systems resilience plan for winter 2015/16. These plans set out our vision for developing effective community services, diverting care aware from our acute hospitals and integrating local health and social care services.

Richmond CCG is committed to working with its key partners and stakeholders to address these challenges to improve health and care services for the population of Richmond. Our commissioning intentions cover all key areas of commissioning responsibility held by the CCG as set out in the Health and Social Care Act 2012 and subsequent policy guidance. In addition, the commissioning intentions are a statement of intent to indicate outline plans at the early stages of the contracting round.

3. Priorities

Richmond CCG's Governing Body has been at the forefront of developing the CCG's commissioning priorities which are set out in the following table.

PRIORITY	KEY ELEMENTS
Community Services:	• Reviewing existing 2015/16 contracts: in order to strengthen services and identify outcome measures to closely monitor impact. Using outcome measures to strengthen CCG contract management process. • Adopt Outcome Based Commissioning approach for community & social care.
Mental Health:	• Working with stakeholders to achieve parity of esteem to improve mental health services to the level experienced by physical health. • Mental Health Outcome Based Commissioning to be developed for 17/18. • Implementation of the Richmond Learning Disability Strategy for 2014-2017
Primary Care Development:	• Strengthen joint commissioning with Croydon, Kingston, Merton, Sutton & Wandsworth CCGs as South West London Collaborative Commissioning • Work towards implementation of primary care delegated commissioning. • Improve responsiveness and accessibility of primary care services, aligned with NHS Five Year Forward View and the Strategic Commissioning Framework for Primary Care Transformation in London. • Develop collaborative working arrangements with Richmond GP Alliance, including seven day working and Prime Minister Challenge Fund schemes
Urgent care:	• Joint procurement of NHS111 out of hours service. • Development of Systems Resilience schemes with responsibility for ensuring the effective delivery of urgent care for Richmond. • Develop Urgent & Emergency Care strategy with regional U&EC network.
Planned Care:	• Implement priorities of Cancer Strategy; including early detection, living with and beyond cancer; meeting national performance targets by improving clinical interfaces. • Implement QIPP schemes to redesign pathways to strengthen community provision and encourage self-care. • Develop RCAS: including increasing uptake across practices and working with GPs to use RCAS data to inform primary & community service development.
Integrated Care:	• Use Better Care Fund to build on Richmond's position of historic joint working with social care. • Please refer to the OBC programme which is set out in more detail in the 'Community

PRIORITY	KEY ELEMENTS
	Services' section of this document.
Children's Commissioning	• Children's urgent care • Special Educational Needs & Disabilities (SEND) service integration and commissioning • CAMHS – Ongoing Development

Richmond CCG has identified five key enablers for delivering our commissioning intentions. These enablers are detailed below alongside our priorities for these areas for 2016/17. By improving in each of these areas we can ensure the organisation is run effectively and provides high quality, patient centred services to meet the needs of Richmond registered patients.

Enabler	Priorities
Partnerships	• Implementation of the Integrated 3 year Prevention Strategy with Richmond Council • Develop further joint working with members of the Health & Wellbeing Board (HWB) to deliver a joint health & wellbeing strategy. • Develop Integrated Partnership Group and Strategic Partnership Group • Work jointly with other SWL CCGs and NHSE as 'SWL Collaborative Commissioning' to deliver the five year strategy for local health services • Work jointly with CCGs across London and NHSE to develop and deliver the 'Transformation Priorities' for London
Clinical Leadership	<u>GP Clinical networks:</u> • Improve information and data to support networks to enable GP Clinical Networks to support and inform the commissioning cycle • Implement networks development plan <u>GP practice & membership engagement:</u> • Development of membership group quarterly meetings • Develop communications and engagement plan for engaging with general practice • Provision of primary care IT support and GP portal <u>Develop clinical leadership with CCG GPs:</u> • Agree programme for development of GP clinical leads, Governing Body GPs and membership: including appraisals & objectives.
Governance	• Recruit to fill interim leadership & senior management positions • Complete Joint Commissioning Collaborative (JCC) restructuring and implementation of JCC review. • Establish appraisal and review system across the CCG and Joint Commissioning Collaborative • Develop the CCG's governance and assurance framework • Embed Project Management Office approach into the way we run projects and escalate risks and issues • Complete review of corporate services • Develop robust Organisational Development plan
Finance	• Deliver QIPP programme • Support the delivery of the SWL Financial Strategy with SWLCC
Quality and Engagement	• Equality and diversity • Patient experience and safety

- Resilience
- Development of public and patient engagement

4. Engagement

The development of Richmond CCG's commissioning intentions for 2016/17 has drawn on extensive engagement with key partners and stakeholders including patients and the public such as the work we have been doing to understand the outcomes that matter most to patients and carers. We are now embedding these outcomes in the way we plan, buy and monitor services going forward.

Some targeted engagement has also taken place with partners at our Community Involvement Group in August to feed into our commissioning plans for 2016/17. We believe that continuous engagement with and drawing on the expertise of patients, carers, residents, service providers and third sector organisations, is critical in shaping services that are of high quality, value for money and reflect the needs of our local population. Our work on embedding equality into the commissioning of health services is underpinned by engagement with our staff and stakeholders.

Ongoing engagement with partners in the local health and social care economy has been taking place via our Integrated Partnership Group that has been particularly influential in helping us to develop and deliver our Better Care Fund and Systems Resilience plans.

Richmond CCG expects all providers to:

- Demonstrate that they have systems in place to capture, collate and interpret patient and public feedback and are able to evidence the impact of this feedback in future service delivery.
- Demonstrate that they are implementing service changes and improving services taking into account patient and public feedback.
- Demonstrate how they are monitoring the equalities profile of their patients, service users and carers and examining what that information tells them about groups that are over or under-represented in their services.
- Work with Richmond CCG to ensure that patient experience is used to deliver services that are personalised, co-ordinated, safe and accessible to meet the outcomes that matter most to patients, carers and local people

5. Richmond CCG commissioned services

Richmond CCG is responsible for commissioning the following services under the Health and Social Care Act 2012:

- Urgent and emergency care
- Elective services
- Community services: excluding public health provision (health visiting, family nursing, health promotion, sexual and substance misuse services)
- Primary care enhanced services
- Rehabilitation services
- Services for people with a disability
- Mental health including psychological services
- Maternity and newborn (excluding neonatal services)
- Children's healthcare services (physical and mental health)

- NHS Continuing Healthcare
- Fertility services

The NHS requires the commissioning intentions to clearly align with the national strategy for the NHS, show clear links to key health strategy especially in relation to the management of the acute sector and London wide financial planning assumptions and to align with our local Medium Term Financial Strategy (MTFS).

The priorities for the next 12 months also recognise the current Primary Care Joint Commissioning Committee agenda and the working groups that have been established to support it. Specifically including commissioning intentions associated with:

- Implementation plan for the Strategic Commissioning Framework primary care specifications of accessible, coordinated and proactive care.
- Application of the Primary Care Infrastructure Fund (investment programme to accelerate improvements in GP premises and infrastructure such as information technology).
- At scale primary care provider development (e.g. GP federations and networks).
- Roll out of Patient Online (designed to support GP practices to offer and promote online services to patients, including access to records, online appointment booking and online repeat prescriptions)..

The remit of the Joint Committee also includes:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts).
- newly designed enhanced services

Richmond CCG is working alongside other south west London CCGs to take on delegated commissioning arrangements from April 2016.

6. Richmond CCG population

Overall, Richmond is healthy, safe and rich in assets. Life expectancy is high and mortality is low. Levels of crime and accidents remain low compared to the rest of London. We have many green spaces, high educational attainment and high levels of volunteering.

However areas where we can improve include:

6.1. Maximising prevention opportunities

- Despite favourable comparison with London and England, estimated numbers of people in Richmond with unhealthy lifestyles are substantial:
    - An estimated 17,000 (11%) adults in Richmond smoke. Annually in Richmond, around 200 deaths are attributable to smoking, and over 1,000 hospital admissions are due to smoking related conditions.
    - Approximately 3,300 primary school age children are overweight or obese. In reception year, 18.1% of children are overweight or obese, making Richmond the sixth lowest

local authority in England. In Year 6 the prevalence rises to 24.4%; this is the lowest prevalence in England.

- Almost half of adults (approximately 65,000) are estimated to be obese or overweight. One in six adults (approximately 25,000) are estimated to do less than 30 minutes of physical activity a week.
- Whilst levels of fruit and vegetable consumption are higher than in London as a whole, fewer than half (43%) of residents achieve the standard of 5 portions per day
- Survey results have shown that only 23% of residents use outdoor space for exercise or health reasons. While this is higher than the average for London (11.8%), the use of the many green spaces in Richmond could be improved.
- Estimates indicate that Richmond has higher than average proportions of increasing-risk (21.3%) and higher-risk (7.8%) drinkers compared to England.
- Alcohol-specific mortality is higher than the London average but similar to the England average, with a rate of 18.8 per 100,000 in males and 6.6 per 100,000 in females. Richmond has lower rates of alcohol-specific and related hospital admissions compared to London and England - for females, recent rates remain stable but, for males, many indicators are showing an increasing trend.
- On the other hand, alcohol-specific hospital admissions for under-18s have been decreasing in Richmond, which is similar to the national picture.
- The rate of hospital admissions due to substance abuse in those aged 15-24 years is 5th highest in London.

- Recent evidence is emerging that healthy lifestyles such as avoidance of tobacco, alcohol, poor diet and physical inactivity can reduce the risk of dementia
- National prevalence models suggest that there are large numbers of people with undiagnosed long term conditions in Richmond (e.g. 2,700 people with undiagnosed coronary heart disease, and 4,850 people with undiagnosed diabetes).
- The overall mortality rate from causes considered preventable in Richmond is low. However, the rate of under-75 mortality rate from liver disease considered preventable is higher than average (16.6 per 100,000) and is increasing nationally (although across London is decreasing).

6.2. Reducing health inequalities

- Life expectancy is about five years lower for men and four years lower for women in the most deprived than in the least deprived areas within Richmond (mainly due to cancer, respiratory and circulatory diseases for men and respiratory, circulatory and digestive diseases for women).
- Eleven out of 115 small areas in Richmond with around 18,000 (9%) residents in total have levels of deprivation above the England average. An estimated 3,140 (8.8%) children in Richmond are living in poverty.
- There is wide variation between schools in the numbers of children eligible for free school meals and also a gap in educational attainment. Attainment is strongly associated with social background. 36% of children eligible for free school meals achieved a good level of development at the end of reception and 69% achieved level 4 or above in Key Stage 2, reading, writing and maths, compared to 64% and 89% for non-eligible children, respectively.

- In 2013 there were 95 people who identified as being gypsies and travellers. Half of these live at a recognised permanent site, and evidence suggests that their health is similar to that of the surrounding sedentary population.
- Homelessness causes significant health problems and local services need to consider this vulnerable group. While there are only few homeless people, their health costs are high. Over 2013/14, the number of rough sleepers seen in Richmond was 101, which is high compared to other south west London boroughs, such as Wandsworth (47). Relevant factors include the location of public transport terminals and the relative affluence, safety and abundance of places for rough sleeping in the borough.
- Low income, poor energy efficiency and energy prices ("fuel poverty") are strongly linked to living in homes that are not sufficiently warmed. In Richmond borough, the percentage of households that experience fuel poverty is approximately 7.6%, lower than the average for England (10.4%) and 11th lowest among the London boroughs.
- Of those aged 16-18 years, 4.5% are not in education, employment or training. Only 8.2% of working age adults receiving mental health services in Richmond are in paid employment.
- People with disabilities are more likely to suffer a range of barriers and are at higher risk of other health problems. 21,447 (12%) people report that they have some form of disability or health problem that affects their day-to-day activities. This ranges from 2.3% (862) of children (0-15 year-olds), to 79% (2,774) of people aged 85 and over. 2,802 (2%) people aged 16-74 years consider themselves to be economically inactive due to a permanent sickness or disability.
- In Richmond, 451 adults with learning disabilities are known to general practice. People with learning disabilities generally have higher health needs and more complex health needs than the rest of the population.
- People from BME groups are more likely to have poorer health than the white British population. 26,265 (14%) categorise themselves as belonging to a Black and minority ethnic (BME) group.
- Both the lesbian, gay and bisexual population and the transgender population are at higher risk of many mental and physical health problems.
    - Estimates of the LGB population vary. A conservative estimate of 5% equates to 9,500 people in Richmond.
    - There may be between 16 and 39 people with gender dysphoria in Richmond and in 2012/13, six individuals in Richmond were referred for support to the West London Mental Health Trust Gender Identity Clinic.
- It is important that health and social care services are aware of the need to respect and be sensitive to the preferences of people of particular religions and beliefs relevant to the services they deliver. In Richmond, the proportion of the population reporting themselves as Christian is declining and those reporting no religion increasing. Compared to London as a whole, Richmond has a higher proportion of Christian (55% vs 48%), a higher proportion reporting no religion (28% vs 21%), and lower proportions of other religions (e.g. Muslim: 3% vs 12%).

6.3. Minimising harms and threats to health

- Approximately 15,800 provide some level of unpaid care and 15% of those provide more than 50 hours unpaid care per week. Carers are more likely to report health problems compared to those who do not provide care and this risk of poor health increases with the number of hours of unpaid care that are provided.

- Children and young people most at risk of poor outcomes include those affected by parental mental health problems, parental misuse of alcohol and drugs, domestic violence and financial stress. It is estimated that around 255 children aged less than 5 years live in households where there is a known high risk of domestic abuse and violence. In Richmond, there are 85 children in care.
- Wellbeing (good social, emotional and psychological health) is associated with healthy behaviours, positive mental health and educational attainment. While most children and young people in Richmond have high levels of wellbeing, there is considerable variation in levels of wellbeing with gender and across age groups.
- The dynamics of family context are an important factor in relation to mental wellbeing and particularly the wellbeing and healthy development of children and young people. It is important to note that 70,998 (47.3%) Richmond adults are married, 665 (0.4%) are in a same-sex civil partnership and 15,271 (10.2%) are separated or divorced.
- The most frequent mental health problems in the teenage years include anxiety and depression, eating disorders, conduct disorder (serious anti-social behaviour), attention deficit and hyperactivity disorders (ADHD) and self-harm.
- In 2013/14, there were 107 hospital admissions as a result of self-harm in those aged 10-24 years, which equates to the highest rate in London. The highest rates of self-harm related A&E attendances and hospital admissions are in females aged 15-24 years. On average, around 12 Richmond residents commit suicide per year, with young and middle aged men, people in the care of mental health services, people with untreated depression, those with a history of self-harm and people who misuse drugs and alcohol being most at risk.
- The age profile of mothers giving birth in the London borough of Richmond upon Thames, London and England in 2011 is older than the London and England averages – 33.6% of mothers in the borough were aged 35 or over, compared to 19.8% in London and 16.1% in England.
- Richmond has the highest proportion of people aged over 75 and living alone in London (51% in Richmond vs. 35% for London). A survey found that just under half of adult social care users feel they have as much social contact as they would like. Feeling isolated and lonely has a profound negative effect on health.
- There has been a downward trend in the percentage of people who die in winter months (excess winter deaths) in Richmond. Older people are most susceptible to higher death rates in winter. In those aged 85 years and over, there were 26 (14.3%) additional deaths in winter in Richmond, compared to 62 (15.2%) in all age groups. This is similar to London and England.
- Screening coverage of eligible women for breast (70.7%) and cervical (72.8%) cancers is lower than the national averages (respectively 75.9% and 74.2%). Whilst this suggests opportunities for improvement, these figures do not include women attending screening at private clinics, which may disproportionately underestimate true coverage in Richmond.
- Childhood MMR vaccination coverage in Richmond is below the England average (77.3% of children have received 2 doses at before the age of 5, compared to 88.3% in England) and there is variation in coverage by GP practices.
- Neighbouring borough Hounslow has one of the highest tuberculosis incidence rates in London at 69.0 per 100,000 (Richmond 8.0/100,000).
- In Richmond, over 40% of acute sexually transmitted infection (STI) diagnoses are among those aged 15-24 (similar to London). 8% of women and 11% of men presenting with an acute STI are re-infected within a year. STI rates have remained relatively stable over recent years in Richmond, but there have been increases in herpes and gonorrhoea.

- Prevalence of diagnosed HIV is one of the lowest in London, but still higher than the England average, and Richmond is officially classed as a 'high prevalence' area. The Richmond diagnosed HIV rate is 2.4 per 1,000 population aged 15-59 years. Around 40% of cases are diagnosed late.
- Although Richmond has some of the best air quality in London, we compared poorly with some national indicators as London overall has lower quality air than England.
- Based on national data modelling, the percentage of residents exposed to unacceptable levels of transport noise (road, rail and air) during the daytime (estimated over 20,000 people) and night time (estimated over 30,000 people) appear higher than in England. Noise pollution can reduce quality of life, increase stress levels and may increase the risk of heart problems.

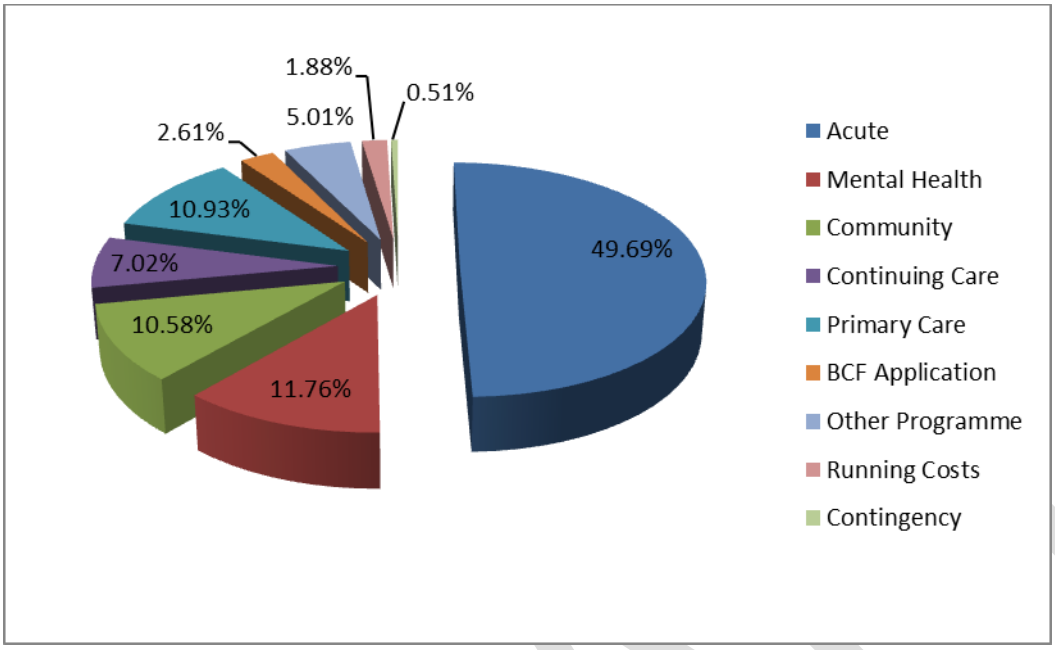
6.4. Planning for increasing numbers of people with multiple long term conditions and promoting independence

- Nearly one in three people registered with a GP in Richmond has one or more long-term condition and nearly one in ten has three or more. The number of people with three or more long-term conditions increases from 4% in people under the age of 65 to 44% in those over the age of 65. There is a clear need for integrated care of multiple conditions within the health care system, and this is a priority of Richmond's Health and Wellbeing Strategy.
- In Richmond, almost 32,000 of the GP registered population have a heart condition (including congestive heart failure, hypertension, ischaemic heart disease and atrial fibrillation). Multi-morbidity is common; over 15% of people with a heart condition in Richmond have at least three other long-term conditions. In addition, 20% of patients have either depression or anxiety.
- There are 5,840 patients of all ages with diabetes in Richmond. Ninety percent of people with diabetes have co-morbidities. Diabetes is a major cause of premature mortality.
- Around 1,700 people are estimated to have some form of severe mental illness. There are about 2,000 people recorded to be in contact with specialist mental health services (1,441 per 100,000, lower than England and London averages). Co-morbidity among psychiatric conditions is high. In addition, an estimated 22,000 people in Richmond have a less severe, common mental disorder (such as depression and anxiety) and there 6,164 adults identified with depression by GPs. In Richmond, each month around 10% of people estimated to have anxiety or depression enter treatment under the Improving Access to Psychological Therapies (IAPT) programme. About 50% of people completing IAPT therapy move to recovery.
- Overall, the emergency hospital admission rate is among the lowest in the country. However, around 2,000 (15%) emergency admissions (costing £4.2 million per year) are for potentially preventable conditions. Emergency readmission rates (11.6%) are similar to London 11.8%.
- The number of 0-4 year olds attending A&E in Richmond is significantly above the national average. The majority receive no investigation or significant treatment, or are discharged without follow-up. In this age group, respiratory disease and infections are the main reason for emergency admissions and GP consultations.
- The number of A&E attendances fluctuates over the course of the year (high in winter), over the course of the week (high on Monday, lower attendance in weekend by older people), and over the course of the day (peak mid-morning, for children a second peak is seen around 7pm).

- Deaths in hospital have reduced year on year since the implementation of the End of Life Care Strategy in 2008. A high proportion of terminal admissions (49%) are for those aged 85 years and above compared with the England average (38%).
- Nine per cent (£1.5 million per year) of spend on emergency admissions is attributable to care homes. 33% of emergency hospital admissions from care homes are short-stay (0 or 1 day) suggesting there is potential to reduce these.
- Delayed transfers of care (DTOC) from hospital are an important measure of the quality of the interface between health and social care services. The rates of DTOC (8.1 per 100,000) and, in particular, those which are attributable to social care (2.3 per 100,000) are high compared to similar boroughs.
- There are 1,780 people recorded as having multiple sclerosis, Parkinson's disease or epilepsy. Long term neurology conditions like these tend to be incurable and progressive in nature, and particularly towards the later stages of the disease impact on quality of life.
- It is estimated that 2,072 Richmond residents have dementia. Around 64% of the estimated number of people with dementia has received a formal diagnosis, which is higher than the national average but lower than the London average and below the target of 66%. Of those with dementia, 70% have one or more other long term conditions, and it is estimated that two-thirds of those with dementia live in the community.
- Cancer prevalence and incidence are increasing nationally. While compared to other areas in England the overall cancer incidence is lower in Richmond, breast cancer incidence is relatively high. The survival rate is generally above average and increasing.
- The employment rate of those with long-term health condition is 4.2% lower than the overall employment rate.

7. CCG commissioning budget

The following diagram and table sets out the CCG's planned spend for its £228.5m (2015/16) commissioning budget. 50% is planned to be spent in the acute sector, 12% on mental health services, 11% in community services, and 11% on Primary Care.



2015/16 PLANNED SPEND BY COMMISSIONED AREA		
Acute	113,535.81	49.69%
Mental Health	26,858.34	11.76%
Community	24,183.74	10.58%
Continuing Care	16,050.00	7.02%
Primary Care	24,980.40	10.93%
BCF Application	5,968.00	2.61%
Other Programme	11,450.65	5.01%
Running Costs	4,287.00	1.88%
Contingency	1,160.00	0.51%
	228,473.94	**100.00%**

8. Quality

Richmond CCG wants to improve the quality of out of hospital health and social care to achieve the outcomes that are important to the people of Richmond. To do this, Richmond CCG and Richmond Council are working in a Strategic Partnership to change the way services are commissioned to deliver the outcomes that matter to patients, service users and the people that care for them. To do this we are using an Outcomes Based Commissioning (OBC) approach, which changes the focus from being about how services operate (activity and processes) to what services achieve outcomes.

Richmond CCG is working with partners to progress Richmond's Mental Health Crisis Care Concordat action plan which is an agreement and action plan between services and agencies involved in the care and support of people in crisis in Richmond. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental

health crisis. The action plan sets out how Richmond CCG and its partners (Richmond Council, South West London St George's, Richmond Wellbeing Service, Metropolitan Police, London Ambulance Service, Richmond Borough Mind and South West London Commissioning Collaborative) will work together to improve:

1. Commissioning to allow earlier intervention and responsive crisis services
2. Access to support before crisis point
3. Urgent and emergency access to crisis care
4. Quality of treatment and care when in crisis
5. Urgent and emergency access to crisis care

The partnership delivering this action plan sets out to meet every two months with the purpose of monitoring progress against the action plan and identifying opportunities to work together to improve the care of those experiencing a mental health crisis.

Work will be underway in 2016/17 to commission quality checkers to check the quality of learning disability services in the borough. More information can be found in section 9.2.

A key area of concern for our member practices, seen in the CCGs amber warning card quality reporting mechanisms includes the lack of follow through after diagnostic testing. The CCG will mandate a local quality KPI that ensures secondary care providers adhere to minimum GMC requirements.

9. Priorities

Our commissioning intentions are organised around our agreed commissioning priorities. The enabler for the priorities is joined up IT systems. We would like to ensure that high quality clinical information is accessible in an integrated, shared clinical record, in real time, at the point of care. It is important for provider clinical and IT systems to be fully compatible with our GP IT systems as this will enable shared information to support integrated joined up care which should lead to better information to support clinical decisions. The overall benefit of this interoperability is improved communication between clinicians across traditional boundaries resulting in faster turn-around times for decision making across the health community.

- Community services
- Mental Health
- Partnerships
- Primary care development
- Urgent care
- Planned care
- Integrated care
- Children's commissioning
- IM & T

9.1. Community services

In April 2014 Richmond CCG and Council embarked upon a Case for Change to look at the provision of health and care community services in Richmond. The report concluded that there was a clear case for changing the way in which community services are commissioned in the borough of Richmond. The key problems are:

- The public's experience of the system appears to be fragmented and does not focus on improving outcomes for them in a holistic way.

- Staff do not feel the way the service is commissioned and managed enables them to do their best for patients; rather it forces them to work in "silos" when they would rather be working in integrated teams.
- GPs experienced unexplained variability in access to and engagement with the services, which has a potential impact on service quality and efficiency.
- The current contracts are poorly designed and not effectively managed. Key performance indicators (KPIs) focus on inputs and processes, rather than improvements to patient health.
- Even if the contracts were well designed, it is not clear that the commissioners have the capacity to manage them and hold the providers to account for delivering value for money.

The outcomes that matter to the public indicate that the providers of community services and out of hospital care should be incentivised to develop a collaborative and consistent approach to care management, which involves the patient, and focuses on the outcomes that are important to them. Below is a high level schematic of the key outcomes:

The outcomes that matter most to Richmond public

Richmond CCG and Council have asked a selected group of local organisations to come together as a group of 'Co-ordinating Providers' to develop solutions for and deliver the outcomes based contract. These providers are:

- Hounslow and Richmond Community Healthcare NHS Trust;
- Richmond General Practice Alliance;
- Kingston Hospital NHS Foundation Trust; and
- West Middlesex University Hospital NHS Trust

In 2015/16 work is underway to develop the adult out of hospital care contract which will be active from April 2016 and include the following services:

- Urgent care pathway
- Community health services
- AQP
- Locally commissioned services
- Continuing healthcare
- End of life care
- Planned care
- Other non-acute, transport and NHS 111

The CCG's plans for Community services are described in detail in a document titled 'Invitation to Submit Detailed Proposals' which was sent to our Most Capable Provider Group (MCP) during the first week of August 2015.

The intention is for community mental health to be phased into the contract from April 2017 to address the parity between physical and mental health (see section 9.2 for more details).

9.2. Mental health services

Richmond is committed to continue to work towards achieving parity in access and services between physical and mental health. We will continue to invest in community services to ensure that people as far as possible can be treated within their community, and only need to use in patient services when appropriate. A key enabler for doing this is our intention to include community mental health services in our outcome based commissioning approach. We have already carried out significant engagement with service users, carers and stakeholders, to identify the outcomes most important to people in Richmond and develop an outcomes framework for mental health community services. People in Richmond told us the outcomes important to them in regard to mental health are:

- I want to belong, feel that I belong and feel normal
- I want to be able to live as productively and independently as possible
- I want to feel in control and be able to cope
- I want the services to work together for me and keep me well
- I want appropriate care to be there when I need it
- I want support for me as well as the person I care for (carers)
- I want it to be easier for me to care (carers)

Throughout the next year we will be working with service users, stakeholders and providers to develop our model of care and approach to OBC. The aim is for mental health services to be included in the OBC contract by April 2017 at the latest. Richmond's intention is to work with our stakeholders, service users and providers to drive the transformation, continued improvement and integration of mental health services. Our initial thinking is to do this using the most capable provider (MCP) mechanism which will evaluate and ensure providers ability to work collaboratively to drive transformation.

We are continuing to invest in community services with planned investment in

- Home Treatment and Crisis services
- Expanding our Primary Care Liaison service
- Continuing our Street Triage pilot service
- Specialist Dementia Nurses
- Dementia post diagnosis care planning DES
- Further investment in Psychiatric Liaison services
- Community services

Richmond is carrying out a review of our mental health accommodation pathway to improve the recovery focus and to ensure we have sufficient capacity. Our intention is to have the services in place to support people in the community and reduce placements in residential care. In addition we will carrying out reviews to guide commissioning for

- Services for people with post-traumatic stress syndrome associated with childhood trauma, and

- Mental health associated with long term conditions for example psychological support for people with diabetes

Dementia Priorities

The GP led model of care will incorporate annual dementia medication review for all patients with dementia in Richmond. This will provide holistic management for patients with dementia.

Learning disabilities

In 2016/17 we will be looking to recommission our community learning disability strategy jointly with Kingston with the purpose of ensuring the contract provides value for money as well as incorporating our Asperger's contract within the main community contract rather than continuing to commission this separately.

A successful pilot of our quality checkers service was conducted in 2014-15, which supported people with learning disabilities to check 30 learning disability services, including community, residential and supported living services to drive up quality. The intention for 2016/17 is to use evidence from the pilot to commission this service and extend this to include quality checks at GP practices and hospitals. There will be on-going support for learning disability employment opportunities in the community in particular large NHS providers.

9.3. Primary Care Development

In 2015/16 plans to work with the other SWL CCG's and NHSE to co-commission primary care services from GP practices were approved, with a view that each CCG would review moving to delegated commissioning arrangements from 2016/17. After a ballot of GP Member Practices in September 2015 the CCG will now apply to move to delegated commissioning from April 2016, subject to a programme of due deligence. This will allow Richmond CCG to have greater influence over the design and development of primary care services. As part of the new arrangements the CCG will expect GP practices to demonstrate that they have systems to capture, collate, interpret and understand the implications of patient and public feedback e.g. patient participation groups, and that they are implementing changes and improving services based on that feedback. Since April 2013 primary care commissioning and contracting has been centrally managed by NHSE, resulting in concerns over fragmentation, access to general practice and the variation in quality between practices.

The move to delegated commissioning will allow CCG's to influence and improve these aspects of local primary care services. The CCG outlined a firm commitment to increase investment in primary care services as part of the out of hospital strategy (OOH). This will be achieved by contracting locally commissioned services (LCS) in a bundle of services that will be delivered for the population as a whole, thus ensuring equity of services across the borough.

Earlier this year the Richmond General Practice Alliance made a successful bid for money from the Prime Minister's Challenge Fund in order to support the extension of primary care services to provide four hubs of primary care operating 8am – 8pm, 7 days per week. The successful bid also includes:

- integrating GP IT systems to allow the hubs access to full GP records,
- development of an app for mobile phones and tablets to allow users to search for local health services, make appointments and order repeat prescriptions amongst other things,
- investing in flat screens at each GP surgery to screen important messages around use of health services and self-care
- to offer bookable video calls between patients and GPs

The hubs, which have been operational since September 2015, aim to make an additional 70,000 GP contacts and 13,000 nurse contacts per year. These developments will have a number of benefits for patients including improving responsiveness and accessibility to primary care services as well as enabling patients to find the most appropriate health services to assist them and take the pressure off our main acute providers. The CCG will continue to work with the Richmond GP Alliance to improve further the standard of quality and delivery of services across population. There will be opportunities for GPs with Special Interest (GPwSI) across specialties including dermatology etc. and community pharmacy.

The CCG is undertaking a comprehensive review of the Locally Commissioned Services; this will determine the future direction of travel. It is expected that the recommendations from the review will lead to redesign (if required) of the existing services or new Locally Commissioned Services being developed in 2016/17 for GP practices and community pharmacies. The recent trend of shifting activity from acute to primary and community settings will require substantial investment in these sectors. Richmond CCG remains committed in developing the primary care infrastructure and workforce to deal with the increased workload and complex caseloads as a result of the shift in activity.

9.4. Unplanned care

Richmond CCG is working with other south west London CCGs to re-procure our NHS 111 service which provides an urgent care phone line for healthcare needs that are less urgent than calling an ambulance out via a 999 call. The new contract should be in place by early 2016 and will guide patients through the most appropriate rung of the local urgent care ladder: from self-care and community pharmacy services to access of A&E services.

Existing services such as Pharmacy Urgent Repeat Medicines, Medicines Use Reviews, New Medicines Services will be further promoted with consideration to expansion and broader integration where appropriate.

The successful bid for Prime Minister Challenge Fund enables us to develop our urgent care offer for 2016/17 by developing our primary care hubs and investing in integrated IT to have alternative services running seven days per week so that patients can access healthcare via their GP hub as an alternative to attending A&E (see more info under section 9.3). The intention is to commission extended hours services via primary care hubs.

We also intend to build on plans for system resilience that were put in place over winter 2014-15 to take the pressure off acute hospitals over the winter months when they receive increased levels of emergency admissions and A&E attendances. Work has taken place to evaluate the effectiveness of the winter 2014/15 schemes in order to inform our plans for winter 2015/16 which will in turn inform our commissioning intentions for winter 2016/17.

We will continue to work closely with Richmond System Resilience Group (SRG), as well as Kingston and Hounslow SRGs to deliver our plans and to work in partnership to direct care away

from our acute hospitals and towards community and primary care services, including increasing the provision of seven day services provided in the community.

Our schemes for winter 2015/16 include:

Under 5s same day access
The aim of the scheme is to reduce the attendance of under 5s presenting in the acute trusts A&E departments and to see a reduction in the A&E denominator for four hour waits.
This will be achieved through utilising the provision of the Richmond GP Alliance locality based hubs and the provision of additional primary care access for patients under-five years of age.
Educational sessions are to be provided by consultant paediatric colleagues for GPs and A&E staff focused on the management of acutely unwell under 5 year olds.

Support for nursing homes
The aim of the scheme is to offer greater support, education and rapid access to clinicians that support the management of care in the community setting. To reduce the number of ambulance contacts specifically relating to A&E inappropriate referrals and palliative care.
A nurse liaison office will provide support to staff in nursing homes, with the aim of reducing the attendance of over 85s in A&E and work towards changing the help-seeking behaviours of nursing homes, through empowering nurses to become competent and confident in the management of their patients. And ensure effective communication across the health economy to enable a higher quality of care Service options will be considered for medicines optimisation advice to care homes to minimise side-effects such as falls and confusion, in addition to poor concordance casuing under- or over-treatment.

Rapid assessment team
The 'Flying Rapid Assessment Team' will comprise of an extended RRRT and RGPA GP clinical input. Currently RRRT operate from 8am to 6pm, this will be increased to 8am to 8pm with referrals for managing emergency home care packages and patients at home being extended to 8pm, 7 days a week.

A GP will be on duty between 8am to 6pm Monday to Friday, to offer rapid medical assessment at home to acutely unwell patients and in conjunction with RRRT. At weekends the GP element of the service will be provided by East Berkshire out of hours service.
The GP element includes: liaison with A&E consultants and medical staff to enhance patient discharge; GP 'surrogate' service; hospital RAG board rounds and patient discussions; medical prescribing; interpreting pathology results; staff training; clinical leadership; and joint visits with members of the team.

Hospital in-reach team
The Hospital In-reach Team (HIT) element supports the hospitals discharge function through community teams and provides a senior community matron (or equivalent) to attend the acute trusts morning Board Rounds on the Acute Medical Units, who will be supported by the expanded RRRT and RGPA GP as part of the Flying Rapid Assessment and Treatment Team bid.
The aim is to identify blockages in the patient pathway, and assess complex patients with the ward staff, for the patients suitability to transfer to the community settings, and includes step-down beds at TMH.

Nightingale service
Richmond Age UK Nightingale service provides support to patients over 85 years, with planned hospital discharge to the patient's home and or place of residents. Support includes arranging transport; ensuring the patients place of residents is comfortable, food and amenities are available as appropriate to support the patient at home.

The support offers additional voluntary support services to Richmond elderly residents at home and links into the community independent living service (CILs) hubs that support vulnerable people in Richmond. The service is available 9am to 5pm Monday to Friday, with an emergency service available 5pm to 8pm Monday to Friday and 10am to 6pm weekends.

Psychiatric liaison
South west London St Georges mental health trust and north west London mental health trust psychiatric liaison nurse in the acute trusts ED, to contribute to the decision making processes around patients and carers with mental health needs. With the aim of reducing the 4 hour mental health related breaches, and 1 hour response times. The provision of ED staff training in patient and carer experience.

9.5. Planned care

Richmond CCG has developed a cancer strategy for 2014-16 which sets out our commitment to improving patient outcomes in cancer and all aspects of care by improving the patient and carer experience across all pathways of care and throughout all stages of cancer. The Strategy sets out 3 priority areas for improvement:

- early detection
- living with and beyond cancer and
- clinical interfaces affecting performance

Work to take forward recommendations and an action plan is now underway and aims to achieve education and training for GPs and all practice staff around cancer awareness, improved cancer screening uptake, and support for people living with and beyond cancer supported by the pan London cancer services commissioning intentions. The CCG is also considering a locally commissioned service focusing on the holistic management of cancer patients in primary care, this would include long appointments and frequent medication reviews. The LCS will be designed with the intention of helping patients living with and beyond cancer which is both a local and SWL priority.

The CCG's QIPP programme covers a range of schemes designed to deliver improved health outcomes in the most efficient manner possible; using examples of evidence-based best practice to ensure patients receive the best treatment in the most appropriate setting.

Planned care
During 2015/16, the QIPP programme identified conditions which could be managed in 'out of hospital' settings through encouraging improved patient self-care, management in primary care with GP support and identifying community services which benefit patients by being treated closer to home. For the remainder of 15/16, the CCG will be developing QIPP schemes in the following clinical areas:

- Cardiology
- Gynaecology
- Pain management

The development and scoping process will identify whether there is a gap in existing services which is to be addressed or if the solution is to develop or enhance existing services to ensure the most appropriate care is in place for Richmond residents. For Gynaecology service we are extending our arrangements with Chelsea and Westminster NHS Trust, the cardiology service will be reviewed this year.

Telehealth

The QIPP programme is currently introducing innovative ways of providing care to patients with obstructive sleep apnoea (OSA) started in September '15 and heart failure (HF), with 'telehealth' services due to be in place later in the year. These schemes work by monitoring patients with OSA and HF, with information being sent directly to specialist nurses who contact and work with patients when this information suggests the patients' health is deteriorating.

It is expected that benefits to patients' health will be demonstrated towards the end of the current financial year, with both services running at full capacity for 2016/17. In addition, introducing a COPD Telehealth scheme for impact in late 2015/16 is being explored to support a wider exercise currently underway to strengthen existing support to residents suffering from respiratory conditions.

Integrated care

Particular focus is being given to supporting elderly Richmond residents, who are more likely to suffer from health conditions and the QIPP programme includes a number of existing and new schemes designed to keep residents well and out of hospital by ensuring health and social care work together. These include:

- Community geriatrician service: in place from autumn 2015
- Locally commissioned GP service to identify patients at high risk of becoming ill and developing care plans to prevent this: underway.
- Flu and pneumonia vaccination programme: raising awareness of GP and community pharmacy services available
- Working with care homes to reduce the number of residents admitted to hospital because of severe urinary tract infections and medicines optimisation.

Pathology & Diagnostics

The CCG has a QIPP scheme which supports Kingston Hospital NHS Foundation Trust in implementing 'Ordercomms', a system which will reduce number of unnecessary and duplicate pathology testing, therefore delivering financial benefits and reducing the amount of tests patients are required to undergo.

The CCG is also in the process of exploring the potential to introduce a 'diagnostic cloud', which would also drive efficiencies by allowing wider access to patients' results, therefore reducing the need for further unnecessary diagnostic tests being carried out. A further potential QIPP scheme for 2016/17 involves introducing community MRI scanning, with the aim of improving access for patients through reducing waiting times and a service which is closer to home.

The latter two schemes are in the early stages of scoping and wider stakeholder engagement would commence should an opportunity be identified in respect of taking these forward.

Develop Richmond clinical assessment service (RCAS)

RCAS is our referral management service which involves GP peer review of eligible referrals from general practice, to address high rates of referral to acute care, reduce unwarranted variation between practices and improve the quality and consistency of referrals.

This year we will be focussing on; increasing the use of RCAS by Richmond practices, improve the quality and consistency of referrals and using the data and information from the increased usage to identify variance in referral patterns and to inform the development of new or re-designed primary & community services

9.6. Integrated Care

Richmond CCG and Council are working together, with other stakeholders to support integrated care through the use of the pooled Better Care Fund (BCF). Our plans intention to invest in integrated community services that provide care closer to home and reduce the number of

emergency hospital admissions. In addition these schemes set out to reduce the number of delayed discharges of care, reduce the number of admissions to care homes, increase the effectiveness of reablement, increase patient/service user experience of care and increase the number of people that die in their usual place of residence.

We also progressing with the implementation of our plans for outcomes based commissioning (OBC). We believe that focus on outcomes should mean a better service for our patients. This approach enables the CCG focus on exactly the health outcomes that we want the provider to achieve for our patients. For both the CCG and providers it encourages a knowledge driven approach to practice. Overall outcomes can link into personal targets and appraisal systems, achieving outcomes can be both collectively and individually motivating, particularly where the absence of clear achievements, goals and targets in the past has tended to produce an approach which spurns the concept of success. We are working very closely with all our providers to arrive at good set of measures that will be beneficial to both raising the quality of the service and for enhancing working relationships

Our current plans set out the work that will be supported through the Better Care Fund for 2015/16, including:

- A GP led model of care which puts GPs at the heart of patients' care and puts in place care plans for the 3% of patients most at risk of an emergency hospital admission
- Psychiatric liaison services in both Kingston and West Middlesex hospitals
- Community geriatrician
- Improving home support services
- Richmond Response and Rehabilitation Team (RRRT)
- Integrated IT systems
- Carers support services
- Increasing role of NHS 111 in integrated urgent care provision

Guidance for continuing the Better Care Fund and possibly expanding its use in 2016/17 have not yet been issued but there is a commitment towards integrated care in Richmond led by our integrated commissioning team who are continually seeking opportunities to create holistic joined up care that considers the full range of needs of patients and service users.

In addition to our Better Care Fund plans our transformational work being undertaken as part of our Outcomes Based Commissioning programme will include the closer integration of adult social care and community health services in order to work together to improve the outcomes of Richmond residents and Richmond registered patients.

Focus on establishing interfaces with secondary care, particularly on the language of building a clinical rapport. Other areas will include:

- electronic interfaces with Outpatients and Emergency Care
- forum for establishing communications with consultants on regular basis
- mandated position or fines re follow ups involving diagnostics tests and not sending back to GP for onward referral etc.
- all providers using diagnostic cloud and roll out across primary care

9.7. Children's commissioning

Following the success of the children's CQUIN in 2014/15 we are planning to introduce this model at Teddington Memorial Hospital walk in centre. The CQUIN aimed to reduce unplanned acute attendances for children in Richmond by having a Children's Advanced Nurse Practitioner at the

urgent care centre in West Middlesex University Hospital who also did a follow up within 48 hours of attendance at the urgent care centre and a second contact seven days later.

Richmond CCG is working with the other south west London boroughs and south west London St George's mental health trust to transform our Children's and Adolescent Mental Health Service (CAMHS) by implementing a new service model by 2016/17 that consists of:

- Single Points of Access
- Dedicated teams for Autism Spectrum Disorder (ASD) /Attention Deficit Hyperactivity Disorder (ADHD), eating disorders and complex learning disabilities
- Improving Access to Psychological Therapies (IAPT)

The aim is to have a transformation plan drawn up by October 2015 which will set out how we intend to spend our children's mental health budget over the next 2 years.

We will be working with the other SWL CCGs to develop an enhanced eating disorders service for 2016/17.

We are in the process of looking at options for the re-commissioning of our risky behaviours contract which looks at reducing risk taking behaviours by increasing protective factors in young people. The existing contract has currently been extended with the intention to re-commission this in 2016/17.

We will be receiving a new allocation of funding for perinatal services in 2016/17 and will be working with other SWL CCGs to explore whether there is potential to jointly commission this service.

In response to the Special Educational Needs and Disability reforms we are working with Achieving for Children and Kingston CCG to jointly commission children and young people therapy services, which include speech and language, physiotherapy and occupational therapy.

9.8. Information Management & Technology

Providers to reach Level 4 of the NHS e-Referral Service Maturity Model by the end of 2016/17. This will be supported by CCG activities to promote ERS utilisation in primary care. CCG to work with CCG partners across SWL to develop a local digital road map in accordance with national guidance

The upgrade of primary care IT infrastructure to ensure provider interoperability, this will be supported by the development of CQUINs. Shared information governance model between health and care providers and between primary and acute (read only terminals in A&E). This will support sharing of clinical information between organisational boundaries in support of direct patient care. Providers to work with commissioners to agree incentives to make progressive improvement in the timeliness, accuracy and completeness of data in patient records – CQUIN development

A key enabler to integration is the ability to access patient records in a timely manner via a secure system. The CCG will continue to work with partners to develop a summary care record which can be accessed by all relevant professionals in a timely manner. Work has already commenced on this and the CCG and partners have been evaluating the system which is in use in NWL and the Kingston Health Passport which is in use in Kingston and is planned to go live in Sutton CCG/LA towards the end of the year.

Opportunities offered by community pharmacy access to summary care records will be explored when available to further improve access to integrated care locally.

10. Summary

Commissioning intentions set out the strategic context in which Richmond CCG is operating and describe the key changes we intend to pursue with providers for 2016/17 to enable us to respond to the challenges we face and support the delivery of our financial, quality and performance objectives.

11. Appendix A: South West London Commissioning Intentions

South West London Collaborative Commissioning – Commissioning Intentions 2016/17 Summary	
Work stream	**Commissioning Intentions**
Urgent and Emergency Care	1. Acute providers to meet the full range of LQS by the end of 2016/17 2. Ambulatory Emergency Care(AEC) – introduction of new tariff to support significant increases in AEC activity (trajectory of desired increase to be agreed with providers) 3. Providers to comply with UEC services designation process and contribute to the new SWL UEC Network
Cancer	4. Delivery of the Transforming Cancer Services pan-London commissioning intentions
Maternity Care	5. Implementation of the new specification for maternity services 6. Meet the trajectory to achieve Obstetric Standards of the LQS by 2018/19 – provide a minimum of 144 hours of consultant obstetric presence on acute labour wards by 1st April 2017 7. Meet the trajectory to achieve Settings of Care Standards of the LQS by 2018/19 – provide for 20% of births to be Midwifery-led setting of care by 1st April 2017 and 3% of births to be home-births by 1st April 2017
Children and Young People	8. All providers will meet the new London Asthma Standards for Children and Young People (2015) 9. By the end of 2016/17 every acute provider will meet the acute CAMHS LQS 21 – single access for children and adolescent health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old). Referrals to be available 24 hours a day, 7 days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 12 hours of call 10. Establish and pilot a Children's Surgical Network across SWL which meets the standards of the new London SCN Children's Surgical Guidelines (2015)
Integrated, Out of Hospital and Community Based Care	11. Apply the agreed Integrated, Out of Hospital and Community Based Care Principles Framework for adult community services across the system 12. The Crisis Response initiative, due for implementation in winter 2015/16, will be developed and run with full year effect for 2016/17 13. Data, including activity and outcomes, to understand the impact of services and to inform future commissioning decisions is required
IM&T and interoperability	14. Providers to reach Level 4 of the NHS e-Referral Service Maturity Model by the end of 2016/17. This will be supported by CCG activities to promote ERS utilisation in primary care 15. The co-development and introduction of a shared information governance model between health and care providers in SWL, to support sharing of clinical information between organisational boundaries in support of direct patient care 16. Providers to work with commissioners to agree incentives to make progressive improvement in the timeliness, accuracy and completeness of data in patient records in support of specific use cases agreed within the SWL IM&T Strategy