Introduction

This document describes Kingston CCG’s commissioning intentions for 2014/15 within a broader planning framework, and in relation to the CCG’s agreed principles and established and emerging priorities.

Overall Kingston is a comparatively healthy area and the levels and quality of health services commissioned compare favourably when benchmarked. However, like the rest of the NHS, health care in Kingston going forward faces a number of challenges.

Challenges

The most significant challenges are associated with the changing age profile of our communities. There are more, older people in Kingston than ever before and the numbers will continue to grow. There is an increasing number of older people with multiple long term conditions, often including dementia, and this demands a change in the nature of health care provision. Hospital services for acute needs are still required and important, but increasingly other strategies and types of care provision in people’s own homes and local communities which address a person’s multiple needs are required. In its planning the CCG is therefore seeking to continue to shift the balance of commissioned health services in recognition and support of these changes.

There are also specific and changing needs for children and people with mental health needs, and these are expanded upon in this document along with our shorter term commissioning plans for them.

Whether for older people, children or those with mental health needs, there is a common need for greater integration both between those providing services, and those commissioning services. Kingston CCG is working increasingly closely with RBK in particular as we seek more integrated commissioning arrangements. Together we are seeking more integrated provision solutions, particularly involving primary, community and secondary care health services together with social care and independent and voluntary sector providers.

Drivers for change

The CCG’s longer term planning and these shorter term Commissioning Intentions are informed by Kingston’s Joint Strategic Needs and Assessment and Joint Health and Wellbeing Strategy, the latter having been developed by Kingston’s Health and Wellbeing Board on which the CCG is well represented.

Earlier in the year NHS England published ‘The NHS Belongs to the People - A Call To Action’ to stimulate nationwide debate about the need for change in the NHS. It outlined concerns about unwarranted variation in quality and outcomes across the NHS and said ‘we must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness’. It also referred to the issues above – more older people, more long term conditions, increasing demand for health services, all at a time of rising costs and
constrained funding in coming years. The CCG will participate fully in work around ‘A Call To Action’, and related publications including ‘A Call To Action’, and ‘Improving General Practice – A Call To Action’, and will play its part in planning and bringing about the changes required.

The CCG is expecting national planning guidance in the near future. ‘A Call To Action’ and other recent NHS England publications have indicated that CCGs together and with Local Authority partners will be asked to develop ‘5 Year Strategies for Health and Care’ during the first half of 2014. Within this, and in the shorter term CCGs will be expected to develop a ‘2 Year Operational Plan’ and in Kingston this will reflect these Commissioning Intentions as well as any more detailed national planning guidance including expected 2 year financial allocations (for 2014/15 and 2015/16).

A particular requirement which Kingston CCG must address is the establishment of the **Integration Transformation Fund**, which was first announced in the 2013 government spending review. This will create a local pooled fund to progress the development of community based services, and will be helpful in the CCG’s rebalancing efforts referred to above.

**Approach and Principles**

Kingston CCG is a clinically led organisation and we will continue to make sure that our commissioning efforts have service quality at their heart – that services are safe, effective and provide for positive patient experience. We will use a variety of means to involve patients, groups and communities in our work, so that planning and decision making is informed by their views.

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Dr Naz Jivani  
Chair

David Smith  
Chief Officer
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1. Planning Context

1.1. NHS Planning Guidance

In October 2013 the NHS Chief Executive wrote to commissioners outlining the planning approach for the NHS over the next 5 years, including:

‘Strategic and operational plans – given the scale of the challenges we are facing, we are asking commissioners (CCGs and NHS England commissioners) to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five year perspective is crucial, as commissioners need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time.’

CCGs are expecting national Draft Business Planning Guidance to be published by NHS England by the end of October 2013, with final version by mid December 2013, which will define the structure and content of the two year Operating Plan.

The likely requirement for longer term strategic plans was signalled in NHS England’s ‘A Call To Action’ document published in July 2013. This describes anticipated ‘...future pressures that threaten to overwhelm the NHS’ and identifies some key challenges which can only be tackled by doing things differently within the following set of requirements:

- How can we improve the quality of NHS care?
- How can we meet everyone’s healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

The 5 Year Strategic Plan initial draft is likely to be due by June 2014, with final versions submitted in September 2014.

1.2. Integration Transformation Fund (ITF)

The ITF was announced in the 2013 Spending Review to ‘ensure closer integration between health and social care’. This is described as ‘a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities’. As part of the Operating Plan CCGs are expected to agree 2 year plans with Local Authorities (for 2014/15 and 2015/16) by March 2014. In 2014/15 the CCG will be committing funds to the ITF for established purposes and will need to add to previous levels of funding (an additional £620k is estimated). There will be a substantial increase in the CCG’s contribution to the ITF 2015/16 (an additional £5.9m is estimated).

1.3. NHS Operating Framework for 2014/15

Expected in December 2014 which will include more detailed planning guidance, changes to CCGs’ outcome measures, and details of CCGs’ financial allocations.

These Commissioning Intentions are written at a point in time - they will need to be reviewed and revised as additional national planning guidance is received. They seek to cover the key aspects of the CCG’s commissioning responsibilities, to inform the initial stages of the contracting round for 2014/15.
2. **Principles and Priorities**

2.1. Principles – NHS Constitution and Mandate

Kingston CCG is committed to the principles laid out in the NHS Constitution and to the requirements of the NHS Mandate, briefly summarised here, and will deliver these requirements through its commissioning activities:

**NHS Constitution**

- The NHS provides a comprehensive service, available to all
- Access to NHS services is based on clinical need, not an individual's ability to pay.
- The NHS aspires to the highest standards of excellence and professionalism
- The NHS aspires to put patients at the heart of everything it does.
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
- The NHS is accountable to the public, communities and patients that it serves

**NHS Mandate 2013-15**

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

2.2. Kingston CCG Mission and Values

We are passionate about your health, compassionate about your care. Our task is to:

- help you stay as healthy as possible
- support you in looking after yourself when you are well and when you are not
- make sure the right services are available if you become unwell, and for those services to be safe, effective and provide the good experience you deserve
- listen to you, involve you and be influenced by you
- work with you to continuously improve:
  - the health and wellbeing of people in Kingston
  - the support that's available to help people look after themselves
  - the quality of local health services
- work with you to reduce inequalities in health across Kingston
- become recognised and respected as the leader of the health care system in Kingston

We value:

- healthier lives for people in Kingston
- getting the best possible health improvement and health care for people in Kingston
- health services for local people, shaped by local people
- you being able to say, I'm heard, I'm healthier, I'm cared for
We plan to achieve this by:

- targeting the causes of ill health and premature death
- improving the quality, safety and responsiveness of services
- ensuring good quality health services are available and accessible in a timely way
- developing services across health and social care

We will measure how well we do by:

- your feedback on the services you use
- the improvement in health and life expectancy across Kingston
- the reduction in the health gap between affluent and more disadvantaged areas and people

2.3. CCG Corporate Priorities to 2015

Kingston CCG has established the following corporate priorities applicable to at least March 2015:

Strategic Priorities:

- Sustainable health and wellbeing economy
- High quality, outcome based services
- Reduced health inequalities
- Pathway approach: prevention - primary - secondary - tertiary
- Shared decision making including self-care

Strategic Enablers:

- Shared, integrated vision with RBK
- Integrated commissioning with RBK
- Implement Better Services Better Value:
  - transform unscheduled care
  - shift ambulatory care to community
  - provide long term conditions care
- Integrate intermediate care
- Transform primary care
- Transform mental health
- Create new paradigm relationships with providers

Underlying Assumptions:

- Innovation
- Patient and public involvement
- System architecture broadly maintained
- Stable resource base
- Local political stability
2.4. Local Health and Service Priorities

The CCG’s Governing Body has recently reviewed and revised the CCG’s strategic workstreams to ensure alignment with Kingston’s Health and Wellbeing Strategy, which is owned and championed by the Health and Wellbeing Board. The CCG’s strategic workstreams can be represented schematically as follows:

Sections of these Commissioning Intentions have been developed to reflect requirements in these key strategic areas.

2.5. Broader Strategies

Kingston CCG is fully engaged with other health commissioners (particularly CCGs and NHS England Commissioning), especially in relation to the longer term planning for acute (hospital) sector provision – the Better Services Better Value (BSBV) programme – more information provided in section 3.2.

The BSBV programme closely reflects the need for change in the recently published NHS England (London) document “London – A Call to Action” (see Appendix 2 for a link) which in turn is fully aligned with national “Call to Action” programme (Appendix 2).

3. Joint Commissioning

3.1. Local Joint Commissioning

The CCG is committed to working in partnership with the Local Authority and there are numerous practical examples of this in effect now e.g.

- joint commissioning with pooled budget arrangements for mental health
• joint commissioning for children and young people
• joint commissioning of the Kingston at Home programme (to achieve transformational change in joint health and social care provision)
• Director of Public Health on the CCG’s governing body
• shared top level post of CCG Chief Executive / RBK Director of Health and Adult Services
• CCG Chair is deputy Chair of the Health and Wellbeing Board
• progressing a programme to integrate CCG and adult social care commissioning functions

The CCG and Local Authority are committed to pursuing opportunities to work closely together wherever that has the potential to improve quality and/or efficiency of provision.

3.2. Better Services Better Value

This is the programme of work through which health care systems in SW London and parts of Surrey are working together on longer term planning and commissioning, particularly in relation to acute (hospital) sector provision. BSBV focuses on:

• maternity and newborn care
• children’s services
• long-term conditions
• end-of-life care
• planned care
• urgent and emergency care

NHS England has assured the clinical and financial models underpinning the BSBV programme, which closely reflects the need for change in the NHS England (London) document “London – A Call to Action”. NHS England has asked Surrey Downs CCG to provide further assurance on the level of GP support for consultation on the BSBV options. This process is on-going and will be completed by the end of 2013. Once this assurance is provided, the BSBV programme will hold a ‘meeting in common’ of all seven CCGs to make a final decision on whether to begin consultation.

All London CCGs have committed to working with their local Trusts to implement the London Quality Standards. The LQS set minimum safety standards for critical care, emergency departments, fractured neck of femur pathway, paediatric emergency services, maternity services, urgent care and inter-hospital transfer and acceptance standards. The LQS are based on a recognition that there is a lack of consistency in the quality of healthcare delivery, depending on the hospital attended, the day of the week and the time of day. The intention is to set minimum standards so that patients can be assured that wherever they accessed healthcare, they can be confident of the quality of care they will receive.

Through BSBV, as well as other work, Kingston CCG is working with other South West London and Surrey CCGs, and with Kingston Hospital NHS Foundation Trust, to drive up standards in local hospitals and ensure that we have the safe, sustainable and high quality care for the residents of Kingston.

3.3. Other Significant Joint Commissioning

Kingston CCG is host commissioner on behalf of SW London CCGs for health services commissioned from Kingston Hospital Foundation Trust and South West London & St George’s Mental Health Trust. Kingston CCG is a core participant in the SW London Effective Commissioning Initiative (ECI) through
which jointly developed and agreed criteria inform and ensure consistency in the commissioning of clinical interventions across South West London.

4. Engagement in the development of Commissioning Intentions

4.1. A range of internal and external individuals, groups and organisations have contributed to the initial preparation of the Draft Commissioning Intentions as follows. We will seek to continue to involve all of them and others as we review and refine this draft:

- Patient representatives and groups e.g. through the Patient Participation Groups’ Forum, Kingston Voluntary Action, Age Concern Kingston, Healthwatch and by raising in public at the CCG’s Governing Body
- Providers e.g. through Clinical Quality Review Group Chairs, CCG commissioning leads, South London Commissioning Support Unit, direct contact with provider strategic or planning groups e.g. Kingston Hospital SDIP
- Royal Borough of Kingston particularly through close liaison with the Public Health Department, Director and Head of Adult Social Care and through Joint Commissioning Leads for Mental Health and Children and Young People’s Services
- Within the CCG especially via discussion at Governing Body Seminars, presentations by clinical and managerial leads for the CCG’s strategic workstreams, discussion with the Council of Members, and internal discussion with senior managers, commissioning leads and others

4.2. The initial draft will be revisited by those who have already contributed and there will be opportunities for others to contribute, most notably through the CCG’s Patient Forum and the Health and Wellbeing Board. It is expected that the document will continue to evolve, both as a result of feedback on the initial draft and in the light of emerging national guidance (section 1.)

5. A brief overview of health in Kingston

5.1. Kingston’s population

- Just over 194,000 people were registered with Kingston GPs in March 2013, which is 4000 more than the previous year. This is greater the number of people recorded as living in the Royal Borough of Kingston (RBK) - just over 160,000 – in other words there are a significant number of people who live outside the RBK area but who are registered with a Kingston GP practice. Kingston CCG is responsible for commissioning services for everyone registered with a Kingston GP practice.
- The population of Kingston is forecast to rise over the next 8 years, and by 8.2% between 2011 and 2026.
- The predicted rise in the numbers of over 65 year olds will have implications for health and social care. Between 2011 and 2026 the number of 90 year olds is expected to rise by 54.1%, 80-89 year olds by 18.5% and 70-79 year olds by 33.6%.
- Older people may be frail or have dementia and are more likely to have long term conditions such as high blood pressure, heart disease, respiratory disease, diabetes and arthritis.
- Substantial rises are also projected for children, teenagers and adults age 50-59 years.
- A quarter of the population are from black and ethnic minority communities, and this is expected to rise to a third of the population by 2021. Certain BME populations are at greater risk of illnesses such as diabetes and vascular disease, and often have poorer access to services including mental health care.
5.2. Kingston as a place to live and be healthy

- The health of people in Kingston is generally good, though there are areas of social disadvantage where health is less good.
- Life expectancy is high overall, but this varies between communities, being 5.8 years lower for men and 4.3 years lower for women from the most socially disadvantaged areas compared to the least.
- Premature mortality (death under age 75) is low. Over the last few years death rates from cancer, heart disease and stroke have fallen and are lower than England averages.
- Priorities to improve health and prevent illnesses developing, include stopping smoking, maintaining a healthy weight, taking sufficient exercise, improving sexual health, promoting mental health and wellbeing and addressing excessive alcohol consumption. Leadership for this work is provided by RBK’s Public Health team.
- Kingston has good housing but high house prices, low unemployment, high school attainment, the lowest crime rate in London and low number of road accident casualties.
- Kingston is the third least deprived London Borough. However there are socially excluded and disadvantaged groups in our community, and we are conscious that commissioning needs to address their particular needs. The approach is outlined in more detail in section 7.6.

5.3. Identifying the needs of the population to shape commissioning

- The CCG is guided by the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and other intelligence that identifies where changes to commissioned services will improve the health and healthcare of the population.
- Other high level information about health needs is included in Section 8 which relates to commissioning intentions for the CCG’s strategic workstreams.
- Access to more detailed information, relevant key documents and links are included in Appendix 2.

6. Kingston CCG’s Commissioning Budget

6.1. Scope of CCG Commissioning

CCGs are responsible for commissioning the following range of services, and have responsibility for a financial allocation to do so:

- Urgent and emergency health care
- Elective (planned) health services
- Community health services
- Rehabilitation health services
- Health services for people with a disability
- Mental health services including psychological and substance misuse
- Maternity and newborn health services (excluding neonatal services)
- Children’s health services – physical and mental health
- NHS continuing care
- Primary care prescribing

Notable areas NOT commissioned by the CCG include:

- Specialised services [commissioned by NHS England – see section 17]
- Core primary care contracts e.g. core GP practice services, dentists, optometrists, community pharmacists [NHS England]
- Health visiting and school nursing [RBK Public Health service]
- Health promotion and prevention services [RBK Public Health service]
- Certain vaccination and immunisation programmes [NHS England / Public Health England]

6.2. Financial allocation

6.2.1. In financial year 2013/14 Kingston CCG is responsible for a commissioning budget of approximately £201m. Expenditure in the year is planned to break down as follows across the main health care sectors:

<table>
<thead>
<tr>
<th>Care Sector</th>
<th>£m</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute (hospital)</td>
<td>108</td>
<td>53.5</td>
</tr>
<tr>
<td>Community (out of hospital)</td>
<td>37</td>
<td>18.5</td>
</tr>
<tr>
<td>Mental health</td>
<td>20</td>
<td>10.0</td>
</tr>
<tr>
<td>Primary care (NOT core contracts)</td>
<td>23</td>
<td>11.5</td>
</tr>
<tr>
<td>Corporate costs provisions, reserves</td>
<td>11</td>
<td>5.5</td>
</tr>
<tr>
<td>Compulsory surplus*</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>201</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

* The CCG has a duty not to overspend this financial allocation and to return a surplus

6.2.2. The following provides a very high level summary of provision associated with this spend:

### Acute (hospital) Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st outpatient appointments</td>
<td>79,000</td>
<td>attendances</td>
</tr>
<tr>
<td>Follow up outpatient appointments</td>
<td>137,000</td>
<td>attendances</td>
</tr>
<tr>
<td>Planned day case admissions</td>
<td>13,800</td>
<td>admissions</td>
</tr>
<tr>
<td>Planned inpatient admissions</td>
<td>3,600</td>
<td>admissions</td>
</tr>
<tr>
<td>A&amp;E Attendances</td>
<td>60,400</td>
<td>attendances</td>
</tr>
<tr>
<td>Unplanned admissions</td>
<td>12,200</td>
<td>admissions</td>
</tr>
<tr>
<td>Obstetric and midwifery admissions</td>
<td>6,600</td>
<td>admissions</td>
</tr>
<tr>
<td>Pathology and other blood tests</td>
<td>1,005,200</td>
<td>tests</td>
</tr>
<tr>
<td>Diagnostic examinations and scans e.g. x-ray, ultrasound, MRI, CT, echo, 24 hr blood pressure monitoring</td>
<td>26,500</td>
<td>examinations</td>
</tr>
</tbody>
</table>
| Breast screening examinations (associate commissioner)                                     | 5,000    | examinations                                                                

### Community (out of hospital) Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's services</td>
<td>78,600</td>
<td>contacts</td>
</tr>
<tr>
<td>Services supporting adults at home</td>
<td>147,300</td>
<td>contacts</td>
</tr>
<tr>
<td>Community clinic services</td>
<td>34,000</td>
<td>contacts</td>
</tr>
<tr>
<td>Community hospital bed-based services</td>
<td>480</td>
<td>admissions</td>
</tr>
<tr>
<td>People with learning disabilities</td>
<td>9,900</td>
<td>contacts</td>
</tr>
</tbody>
</table>

### Mental Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult and older people acute bed days</td>
<td>13,300</td>
<td>Bed days</td>
</tr>
<tr>
<td>Rehabilitation bed days (re-commissioned away from inpatient provision for 2013/14)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Adult and older people contacts</td>
<td>40,600</td>
<td>Contacts</td>
</tr>
<tr>
<td>Child and adolescent contacts</td>
<td>4,900</td>
<td>Contacts</td>
</tr>
<tr>
<td>Other specialist services contacts</td>
<td>4,900</td>
<td>Contacts</td>
</tr>
</tbody>
</table>
6.3. Financial pressures

The CCG’s financial allocation for the next 2 years is likely to be announced in December 2013. The government is committed to awarding an increase which keeps pace with published rates of inflation. However it is well established that inflation within the health care sector runs significantly higher than that across the wider national economy. This is linked to at least:

- increasing costs of products and services used by the health sector;
- changes / improvements / developments in the treatments and therapies available, some of which are proscribed at a notional level e.g. by NICE, which must therefore be made available and funded at a local level;
- changing demographics, in particular a growing older population living longer, increasingly with multiple and complex health needs.

The growing funding pressures greatly exceed the annual funding settlements and calculations at national level estimated the NHS needed to absorb financial pressures rising to £20bn per annum by 2014/15 compared with the 2009/10 baseline.

The Call To Action document (section 2.1.) requires CCGs to formulate 3-5 year plans to help solve a funding gap of £30bn by 2020/21 (compared with 2013/14 baseline).

6.4. CCG Funding Formula for 2014/15

NHS England oversaw work to review and revise the allocation formula for 2013/14. However analysis showed that it would have had a significant impact on CCG funding levels and the revisions were not implemented. In 2013/14 NHS England has launched a fundamental review of the CCG allocation policy. A Review Group will publish its initial findings to inform 2014/15 allocations and a final report in July 2014 will inform 2015/16 allocations.

6.5. Integration Transformation Fund (ITF)

In its August 2013 ‘Statement on the health and social care Integration Transformation Fund’ NHS England states ‘The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing...’

Kingston CCG already transfers significant sums to RBK under a number of headings and to support joint commissioning of a number of services. The above Statement commits the NHS to transfer an additional £200m nationally to Local Authorities in 2014/15 as the ITF comes into partial effect. It is estimated Kingston CCG will need to transfer £621k in addition to current transfers.

The ITF comes fully into effect in 2015/16, with the above Statement committing the NHS to transfer an additional £1.9bn to Local Authorities on top of the 2014/15 baseline. It is estimated Kingston CCGs share of this will be £5.9m i.e. approximately 3% of the CCG’s entire commissioning budget.

_With the nationally stated aim for the ITF of ‘expanding care in community settings’ there is a clear system-wide imperative to develop robust plans which will enable reduced spending on acute services (planned and unplanned hospital services) in order to fund the ITF and expand community provision._

This will be an important focus for the CCG’s 2 year Operational Plan.
7. **CCG Strategic Workstreams**

The following sections outline the priorities in the CCG’s strategic workstreams. For each the CCG has a clinical and managerial lead, shown on the schematic in section 2.4.

7.1. **Children and Young People**

7.1.1. Kingston CCG and the Royal Borough of Kingston have established collaborative commissioning arrangements with a single Joint Commissioner working across the 2 organisations. A multi-agency Children’s Health Commissioning Board (CHCB) has been established (CCG, Local Authority, Public Health). This will oversee and facilitate the delivery of a local vision for improving the health and wellbeing of children and young people through the programme of work outlined below.

7.1.2. The agreed joint local vision for services for children and young people is summarised in the following table:

<table>
<thead>
<tr>
<th>The Vision</th>
<th>Away From</th>
<th>Moving Towards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and young people are able to access the right service in the right place at the right time</td>
<td>Professionals silos that co-operate when necessary</td>
<td>Collaborative working across professions and integrated commissioning</td>
</tr>
<tr>
<td>Services are evidenced based and deliver high quality interventions that are outcome focused</td>
<td>Provider led commissioning that reacts to demands</td>
<td>Intelligence led commissioning that delivers outcomes</td>
</tr>
<tr>
<td>Children and young people have a positive experience of care and feel empowered in decisions about their care or treatment</td>
<td>Services offering a stable and predictable environment that meets the needs of their staff</td>
<td>Flexible services that can adapt to fit changing priorities and resources being aligned to need</td>
</tr>
<tr>
<td>Children and young people are supported to achieve their full potential</td>
<td>Fragmented pathways</td>
<td>A ‘whole systems’ approach</td>
</tr>
<tr>
<td>Parents are empowered and confident in looking after their own children</td>
<td>Children, young people and their families being ‘done to’</td>
<td>Children, young people and families having greater choice and share in the decision making</td>
</tr>
</tbody>
</table>

7.1.3. Principles which CCG and RBK together will apply in commissioning services for children and young people include:

- Proportionate response to need and economies of scale
- Services are focused on early intervention, outcomes and recovery
- Teams with expertise rather than individuals with specialism’s
- Shared decision making and management of risk
- Children and young people feel listened to have a positive experience of care
- Greater self management, choice and responsibility for families

7.1.4. The CHCB has agreed the following priority areas to be addressed from now (October 2013) and through 2014/15:

(i) Services for disabled children:

- Implement the new statutory duties of the Children and Families Bill
  - The introduction of a single Education, Health and Social Care (EHC) Plan replacing the current Statement of Special Educational Needs and a joint assessment process
- Extending the age range of the Health, Education and Social Care (EHC) Plan from birth -25 years.
- Publishing a local offer of all the services that will be available to children / young people with a EHC Plan and
- Offering Personal Budgets to children / young people with an EHC Plan

- Address waiting list pressures identified within:
  - Community Paediatrics
  - Occupational Therapy
  - Speech and Language Therapy
  - Social Communication Services (ASD)

(ii) Child and adolescent mental health services (CAMHS) – jointly with mental health commissioning:

- Complete review of the Targeted (Tier 2) Services
- Implement the IAPT programme
- Implement a single point of access and triage model
- Integrate the business processes (risk management, clinical governance, outcome based measurement tools, case management systems)
- Redesign needs led care pathways
- Assess the feasibility and if appropriate and agreed, re-commission services in partnership with RBK and neighbouring CCGs

(iii) Continuing care:

- Continue to improve the quality of the Continuing Care Assessments
- Re-commission the Continuing Care contract
- Offer children, young people and their families Personal Budgets (social care) and Personal Health Budgets (health care)

(iv) Transition arrangements:

- Update the Transition Protocol with adult services to include healthcare pathways
- Review the Transition arrangements for vulnerable groups such as those who are leaving care and those with on-going mental health concerns
- Support the implementation of the Children and Families Bill that will extend the age range of Education, Health and Social Care Plans (formally known as Education statements) to 25 years for those with additional learning and disability needs

7.1.5. The CCG will work with other commissioners and providers of children’s services to assure delivery of ‘universal children’s services’.

7.2. **Older People & People with Long Term Conditions (LTCs)**

7.2.1. The CCG’s out of hospital strategy, which is fully aligned with the associated SW London Better Services Better Value workstream, has the following broad objectives:

- Improving choice and outcomes for vulnerable adults, people with long term conditions and frail elderly
- Care closer to home and in the home
- Avoiding admissions into hospital
• Early supported discharge from hospital
• Integrating care across care settings and providers

7.2.2. Much of the CCG’s effort to deliver these objectives is encompassed within the Kingston at Home programme. The major emphases for Kingston at Home during 2014/15 are:

• Further integration of health and social care community services through the consolidation of Kingston at Home service model and pathways
  – Single point of access to community health services – multidisciplinary team triage and assessment
  – Admission avoidance
  – Early supported discharge
  – End of life care
• The above particularly relates to the following service areas:
  – Reablement
  – rehabilitation
  – intermediate care
  – care homes
  – rapid response
  – community therapies
• Support Your Healthcare CIC (the community health services provider) in the redesign of the medical components of Kingston at Home to enable more people to receive care at home
• Review and redesign of community (district) nursing and community matrons service model and care pathways in light of the caseload profiling project (to be completed November 2013); for implementation in 2014/15
• Explore the requirement for step-up and step-down community beds (Cedars Unit)
• Explore the requirement and service model for assessment bays at Surbiton Health Centre
• Embed consistent use of risk stratification and multidisciplinary team (MDT) care planning and case management, particularly for people at risk of unplanned use of health and social care services. This to be based on GP practice populations, with primary and community staff centrally involved along with social care and mental health services colleagues
• Work with patients with long term conditions to increase levels of patient self-management
• In partnership with RBK (Adult Social Care and Public Health) commission integrated adult prevention services with specific focus on the health funded Age Concern Kingston “Stay Well at Home” Service.
• Subject to evaluation extend telehealth deployment, aligned with Adult Social Care commissioned telecare services

7.2.3. In all of its work for adults and older people the CCG is committed to championing and applying best safeguarding principles and practice. The CCG and RBK have employed staff who are dedicated to ensuring that this is the case, who are also able to plan and provide advice, support and development where necessary.

7.2.4. Personal health budgets (PHB) - the NHS Mandate makes a commitment to offer the option of a personal health budget to people with long term physical and mental health conditions who could benefit, from April 2015. The CCG is progressing development work for PHBs for people with Continuing Health Care needs (section 12.1.), and this will take the potential future extension to LTCs into account. Development work to extend the CHC arrangements from April 2014 to those with LTCs by April 2015 will progressed throughout 2014/15.
7.2.5. Other areas of work where the CCG intends to consolidate and potentially expand in 2014/15 include:

- Continued emphasis on holistic approach to health care and management for older people using the comprehensive geriatric assessment tool and a recovery and rehabilitation philosophy, particularly to enable older people to regain their independence and return home following an acute illness
- Continued support for the provision of dedicated support to care homes (IMPACT team) to achieve the following outcomes:
  - improve illness prevention and clinical management of residents and
  - reduce unplanned admissions to hospital.
  The project was effective from launch in 2012/13, has been extended in 2013/14 and the CCG will seek to consolidate and where appropriate extend further in 2014/15
- Implement a community-based cardiology service jointly with secondary care colleagues
- Continued support for the Patient Centred Angina Management Service pilot which has started in 2013/14 and continues to at least mid 2014/15
- Provide support as necessary to assist RBK’s implementation of the Universal Day Care services model

7.2.6. Future iterations of these Draft Commissioning Intentions will need to take account of the annual Public Health report to be published in November 2013. The section on Long Term Conditions is likely to include recommendations around:

- review of current services
- support for primary care
- risk stratification
- approaches to self-care
- telehealth
- closer integration of mental and physical health including holistic approaches and medicines management

7.3. Mental Health

Kingston CCG is lead commissioner for collaborative mental health commissioning across SW London. Each CCG / Local Authority area has its own priorities within a common framework of intended outcomes. The following reflect Kingston’s priorities across the main workstreams:

7.3.1. Improved access and outcomes within primary and community care settings with the aim of refocussing services towards prevention and early intervention, continued improvement of access into treatment for individuals who have a dual diagnosis (with a focus on mental health and substance misuse). We will review the Kingston Community Wellbeing service with a view to establishing a single point of access into both primary and secondary care mental health services. Other work is to be progressed around retaining Mental Health PbR clusters 11 and 12 (well managed psychosis) within primary and community care settings (within the Community Wellbeing service) and clusters 18-19 (low and medium cognitive impairment, and dementia) within primary and community care settings.

7.3.2. Adult Rehabilitation Services – we have completed work on the redesign of acute sector rehabilitation care pathways, introduction of community rehabilitation services to better support people
in their own homes and to step rehabilitation patients into community supported living accommodation. Commissioning efforts are now focussed on supporting and maintaining these arrangements and working with RBK housing to develop mental health specific housing projects for lower needs.

7.3.3. Personality Disorders (the SUN Project) - review the outcomes of the Department of Health funded SUN project (national funding finishes October 2014) with a view to transition of elements of the services into mainstream Borough based Personality Disorder services

7.3.4. To compete the ‘bedding in’ of Adult Community Mental Health Services in Kingston and review progress against key performance indicators from both Health and Social Care perspectives

7.3.5. Adults of Working age Tier 4 (Acute) bed provision – work with South West London and St Georges NHS Trust (SWLStGs) to support the implementation of their estates strategy, agree a SWL strategic approach to deliver future Tier 4 services and reinvestment opportunities for a dynamic community approach (primary and secondary services). Work will continue in 2014/15 to review the use of inpatient beds to ensure that patients are cared for in the community wherever possible, length of stay and emergency readmission rates are reduced, improvements in the care pathway and discharge and transfer arrangements. Crisis plans must be completed and understood by both provider and service users with users being empowered and central to the development of the planning.

7.3.6. Special Contractual (out of area or specialist) placements - reduce the level of activity within tertiary and specialist services by management and review of secondary care pathways, improved contracting, review and repatriation to local services if clinically appropriate. Linked into 8.3.2 in terms of developing rehabilitation and housing projects within the Borough jointly with RBK Adult Social Care and Housing.

7.3.7. Older Persons Tier 4 bed provision review including reconfiguring OPMH psychiatric liaison services and relationship with Tier 4 provision. Also consider opportunities to provide mental health expertise and / or training to general older people’s service e.g. domiciliary care.

7.3.8. Review of Older Persons Community Mental Health Services – review services and outcomes in relation to need, especially focusing on patients who have cognitive impairment (dementia); consider option to reconfigure into generic community physical health care provision and decommission from specialist mental health provider. Dementia planning is being progressed jointly by all the CCGs in SW London as part of the long term conditions workstream in Better Services Better Value (section 3.2) led by Dr Phil Moore. Review the implementation of the Joint Dementia Implementation Plan and develop a memory service and clinic(s) for early detection and intervention.

7.3.9. Jointly with the Local Authority agree and implement a plan to support carers where possible using direct payments or personal budgets in line with the Carers Strategy

7.3.10. Ensure the CCG has access to improved mental health services for veterans and their families by raising awareness in primary and secondary sectors, ensuring appropriate referral to London Veterans Mental Health Service is made and followed up.

7.3.11. Support to Independent Living – accommodation and support services will be commissioned for people coming out of acute mental health services. This will be funded by reducing length of stay
in specialist mental health (T4) provision and disinvestment in in-patient beds and high cost placements

7.3.12. Co-production of service review and re-design - ‘Mental health in Co-production’ (MiC project) is an approach which puts local people at the centre of commissioning decisions. People who use mental health services, their partners, families and friends know what’s currently working, what isn’t and what needs to change. The CCG will ensure that this knowledge and understanding is at the heart of decisions about local services and use the principles of co-production to change the way in which adult mental health services are commissioned in the future.

7.4. Unscheduled Care

7.4.1. Kingston CCG provides Chairmanship and management support to the local health economy’s Urgent Care Board (UCB) which has the active engagement of all key partners across the system in the development and implementation of a whole system urgent care strategy and associated plans. The UCB has identified a number of priorities for attention:

- Winter planning and preparedness; demand and pressure surge management
- Kingston Hospital – delayed transfers of care
- Kingston Hospital – urgent care centre
- Walk in centres in Surbiton and potentially one more elsewhere in the North of the Borough
- Primary care development – quality, access and prevention of A&E attendance
- Kingston Hospital – speed of specialty review of patients within A&E
- Long term conditions
- End of Life care
- Mental Health
- Frail adults
- Risk stratification
- Paediatrics
- Acute care physician pilot

7.4.2. The UCB has established the following workstreams to tackle the above priorities:

- Unscheduled care strategy
- Primary care access and A&E interface
- Review and effective management of unscheduled care demand and capacity across the whole system (primary, community, secondary and social care)
- Urgent care business intelligence - review of system data & provision of appropriate performance measures
- Review and reduction of delayed transfers of care

7.4.3. Outcomes in 2014/15 are expected to include:

- Improved patient satisfaction with Kingston Hospital’s A&E and other unscheduled services
- Kingston Hospital maintain achievement of the 4 hour A&E waiting time target
- Reduce delayed transfers of care at Kingston Hospital – enable priority discharge to home
- Services outside Kingston Hospital A&E (walk-in centres, urgent care centres) seeing patients that previously would have attended at A&E
- Through commissioning and contract management processes the CCG will seek to ensure that all targets for unscheduled care are delivered, including those for NHS 111 and GP Out of Hours provision
- NHS 111 appropriately signposting patients to the right services – not defaulting to A&E
- NHS 111 Directory of Services updated and inclusive of all services
- Evaluate the impact of the acute care physician pilot and agree future arrangements
7.4.4. During 2014/15 the CCG intends to explore the feasibility of commissioning

- One or more walk in centres
- An urgent care centre likely to be based at Kingston Hospital

7.4.5. During 2014/15 the CCG intends to develop and progress a tender for elements of unscheduled care provision, informed by recommendations from the planned NHS England evaluation of NHS 111 services in London. Elements to be included are likely to include:

- GP out of hours services
- NHS111

The CCG may also seek to include the services listed in 7.4.4. in any procurement.

7.5. Integrated Care

The CCG is committed to working with other commissioners and providers in the statutory, independent, voluntary and charity sectors to make patients’ and service users experiences of services more ‘joined-up’. Together agencies across Kingston are expecting to make a commitment to Kingston’s Health and Wellbeing Board to deliver more integrated working for the benefit of patients and the local health and social care economy.

Kingston CCG will seek to build on good local examples such as Kingston at Home, children’s disability services, and adult mental health services.

This joint programme of work is likely to grow in significance and scope rapidly from now (October 2013) and through 2014/15, as local agencies together seek to make improvements for patients and service users, at the same time progressing the change necessary to assure sustainability in an environment of increasing need and, at best, static real terms resourcing.

Specific work is referenced elsewhere in this document, particularly important elements being the establishment of the Integration Transformation Fund and associated planning (section 6.5.) and the Kingston at Home programme (section 7.2.2.)

In the short term there is likely to be a focus on:

- Providing a compelling narrative for this work
- Establishing the target group(s) of local population for attention in the first instance
- Making arrangements for population co-design in service change
- Establishing a single point of contact for services
- Setting up engagement arrangements for the agencies involved

7.6. Socially Excluded and Disadvantaged Groups

The CCG has recently added this as a strategic workstream, which further aligns CCG commissioning with the aims and objectives of the Health and Wellbeing Board. As a cross-cutting theme for the CCG, leads in patient-group-specific workstreams and project areas will need to find ways to work with those with responsibilities in this area (including outside the CCG) to ensure the particular needs are taken into consideration.
The CCG will work with Public Health colleagues and others to maintain a shared understanding of those referred to by the phrase ‘socially excluded and disadvantaged groups’.

The CCG will work with Public Health and other colleagues with the aim of aligning its commissioning activities with the commissioning and provision of others, in relation to these Groups. The objective is to ensure all are working together and using the tools at their disposal towards shared goals for socially excluded and disadvantaged groups. Where possible and appropriate the CCG will seek to make specific reference to the needs and required outcomes for these Groups in its commissioning, contracts and associated management and reporting.

The CCG will work with Public Health colleagues, their commissioned services and others to enable socially excluded and disadvantaged groups to be able to contribute to and influence CCG commissioning. The CCG will play its part in joint strategic work targeting the determinants of poor health in Kingston, which will include the particular issues and needs of these Groups.

Where specific needs have been identified which may be addressed through CCG commissioning the CCG will endeavour to include these in in the 2014/15 contracting process. In addition, in areas where the CCG has influence though perhaps not direct responsibility, accountability or resourcing, it will endeavour to work as a partner in pursuit of agreed objectives for socially excluded and disadvantaged groups.

8. Maternity and New Born

- The number of live births per annum has increased year on year since 2001 (1787) to 2011 (2289), an increase over the period of 28%. The numbers are projected to continue rising each year to a peak of 2457 in 2015, and are then expected to settle back to around 2430 per annum by 2019
- The CCG will continue to support and encourage efforts around timely booking, screening and community-based provision via the integrated community midwifery teams
- To help with this the CCG will undertake a brief review of provision and patient satisfaction with services, which will also reference the richer dataset now collected and collated by service providers
- Nationally maternity performance targets are being reviewed; the consequences of the review will be accommodated in the CCG’s contracts
- There is an expectation that changes to the payment by results (PbR) tariff will incentivise acute trusts to provide the most appropriate care depending on mothers’ different needs and enabling choice
- There is some indication that there is an increase in the number of post-natal women who are having difficulty with breastfeeding. The CCG will want to explore this with Kingston Hospital NHS Foundation Trust to ensure there is adequate support to assist women with breastfeeding whilst an inpatient, and that provision and support are in line with good practice guidelines.
- Kingston CCG is an active participant in the SW London and Surrey Downs Maternity Network, through which cross-CCG work on commissioning, service development, pathway redesign and clinical quality standards may be progressed, in partnership with providers, ensuring consistency across the wider area

9. Cancer commissioning

Kingston CCG is signed-up to the pan-London ‘Transforming Cancer Services for London’ programme, which is hosted by NHS England, leads cancer service change, and has identified a
number of priority areas for cancer for 2014/15 which have been included in the draft TCSL Cancer Commissioning Intentions for 2014/15. CCG expenditure, through the CSU, accounts for approximately 40% of spend on cancer services covering the more common cancers, prevention, early diagnosis, living with and beyond cancer (survivorship), and palliative care. The remaining cancer commissioning across London is undertaken by NHS England’s Specialised Commissioning Service, covering the more complex and rarer cancers, and specialist treatments such as chemotherapy and radiotherapy. Kingston CCG has access to a Cancer Commissioning Team to give leadership to the contracting process, and services will be commissioned from London providers which are active participants in their Integrated Cancer System.

The impact of the initiatives will need to be discussed as part of the contracting round and transition pathways agreed. The following summarises the key areas - more detail is available on request:

1. Continued support for population awareness – esp. pop-up shops, cancer activists, ‘Be Clear on Cancer’ campaign
2. Implementation of Early Detection Best Practice commissioning pathways – esp. revision of pathways: ovarian, colorectal and lung cancer
3. Implementation of the endoscopy commissioning strategy – includes increase investment (offset by savings from triage); commission only JAG accredited providers; barium enema not suitable test; robust recall arrangements
4. GP direct-access diagnostic turnaround times
5. Cancer outcomes by MDT
6. Items relating to out-of-hours services
7. Urgent gastroscopy available within 14 days
8. Reduction of variation between providers and within providers – optimisation, increase consistency, reduce overall costs
9. Implementation of Co-ordinate my Care on a consistent basis across London – increase terminal care in place of choice
10. Implementation of living with and beyond cancer elements of the Best Practice Commissioning Pathways – in 2014/15 contracts, indicators for pathway compliance
11. Extension of the Recovery Package – increase numbers receiving, focus on physical activity, work, finance
12. Focused patient experience measures – esp. primary / secondary care interface
13. Consequences of treatment – lymphoedema, pelvic radiation disease, sexual function
14. Supporting people with active and advanced disease
15. Risk-stratified outpatient pathways – reduce follow-ups, increase discharges, increase self-management esp. breast, prostate and colorectal cancer

10. **NHS Continuing Health Care (CHC)**

Demand for and expenditure on continuing health care (CHC) continues to grow, linked to the growing older population and increasing awareness of the scope and criteria for referral for NHS CHC.

10.1. **2013 review**

The CCG has commissioned a review of CHC arrangements which will be completed and reported shortly. We would expect to progress recommendations for change to so that they are effective in 2014/15. Areas where there may be change include:

- more thorough completion of application forms
• more consistent application of eligibility criteria for CHC funding, including fast-track arrangements
• more consistent review processes including initial 3 month and annual reviews
• consider banded pricing and proportionate decision making especially for nursing home placements
• better alignment between prices paid by the CCG and adult social care, particularly in nursing homes
• commissioning process improvements and closer working with adult social care e.g. re home care, nursing care, quality monitoring, information sharing

10.2. Nurse assessment

Having been given notice by the current provider of the nurse assessment service for NHS Continuing Health Care (CHC) patients, the CCG is in the process of redefining the requirement and establishing an in-house team. The nature and scope of provision will be informed by the above CHC review and by the need to offer and support personal health budgets from April 2014 (see 10.4. below)

10.3. Renegotiated prices

The CCG’s commissioning of CHC is aligned with RBK’s Adult Social Care commissioning arrangements, and we will seek provider consistency in pricing, terms and conditions, for example in the recently agreed reduction in rates for home care services. The CCG will seek to apply and extend these arrangements in 2014/15.

Similarly a London-wide ‘any qualified provider’ tariff has recently been agreed by residential and nursing homes to the NHS for continuing care patients. This represents a price reduction, and again the CCG will seek to activate this rate as soon as possible, and certainly in 2014/15. Additional opportunities to link package costs to itemised needs of individual patients may also be explored.

10.4. Personal health budgets

There is a government commitment to introduce a ‘right to ask’ for a personal health budget for people in receipt of NHS Continuing Health Care from April 2014.

Work is underway in the CCG to enable this. The CCG is developing its approach in consultation with service users and other stakeholders, and expects to test out arrangements with a small initial tranche of people before April 2014 – likely to be some of those who have been in receipt of a personal budget and direct patient from Adult Social Care and who have been assessed as eligible for NHS CHC

11. End of Life Care

11.1. A new Kingston End of Life Care Steering Group was set up in April 2013 with a vision to deliver person-centred, good quality, integrated end of life services for local people.

11.2. A central priority is around helping people to die in their place of choice. This means raising the profile of choices in death and dying across all care settings and reviewing options for community based care. The Steering Group aims to promote partnership working across in the full range of relevant settings in Kingston including; acute hospitals, patients’ homes, care homes and supported housing, hospices, community hospitals, ambulance services, social services and hostels for the homeless. The Steering Group also aims to develop and coordinate an integrated system of care
across Kingston and develop a revised Strategy for End of Life Care that will impact the number of hospital deaths.

11.3. Key initiatives which may influence arrangements for 2014/15 or which may be progressed during 2014/15 include:

- Review and update past needs assessment, modelling and service mapping and assess the need for associated action
- Review the impact of recent enhancements to community nursing services which include access to overnight care at home provided by the Princess Alice Hospice in partnership with Your Healthcare CIC
- Improve care in general practice including more consistent and comprehensive maintenance of palliative care registers
- Review and extend the use of a shared electronic record for EoLC patients called Co-ordinate My Care (CMC)
- Continue to pursue better coordination and cooperation across health and social care, including evaluation of past education and plans for future education for professionals, carers and patients
- Improve care in the hospital setting and in care homes, including implementing new national guidance on EoLC when available, analyse and act on EoLC pathways through A&E, provide ward-based EoLC education to multidisciplinary teams
- Agree the best ways to continue to take into account the views of patients and carers
- Review the work of the IMPACT team (section 8.2.3.) – does their work result in lower emergency admissions from residential and nursing homes.

11.4. End of Life Care Local Enhanced Service (EoLC LES) – In 2013/14 the EoLC LES is being used to encourage use of Co-ordinate my Care (CMC), referred to above. This electronic patient record holds information about the preferences of people approaching the end of their life and is accessible to hospitals, hospices, community providers and GPs. It improves integrated working in End of Life Care as well as enabling patients to achieve their choices e.g. around preferred place of care / death, resuscitation arrangements. The CCG will be considering extending this LES for this purpose in 2014/15.

12. Primary Care

12.1. Kingston CCG sees General Practice as an essential component of integrated health and social care provision and of the local out-of-hospital programme. Indeed it has a central role to play in all of the CCGs strategic workstreams. However the CCG does not commission primary care i.e. core general practice provision or other primary care services including dentists, optometrists or community pharmacists, which are all commissioned by NHS England. There is therefore an essential requirement for Kingston CCG and NHS England (London) to work together to ensure that commissioning is aligned to enable primary care to make its essential contribution across local service provision.

12.2. The CCG does commission non core primary care services, as enhanced services. Going forward these are renamed Locally Commissioned Services (LCSs). The CCG will be reviewing and prioritising this portfolio of services, and exploring the potential for change in order to enable primary care contributions to wider CCG priorities.

12.3. NHS England’s ‘Call To Action’ document which signals that the NHS must ‘change to survive’ recognises the central contribution of primary care and identifies some areas for possible change including 7 day access, increased focus on prevention, workforce development. The CCG will be engaging in work around NHS England’s ‘Improving General Practice – A Call to Action’.
12.4. NHS England will shortly publish national Primary Care Commissioning Intentions for 2014/15 which the CCG will take account of. There is also work on-going to develop a Strategy for Primary Care for London which will influence local work.

12.5. Some aspects of primary care which are emerging locally as potential priorities for work include:

- urgent care provision including opportunities for urgent care and walk-in centre provision which would be likely to have significant primary care components
- integration agenda where primary care may be at the heart of integration arrangements in community settings, working particularly closely with community health and social care staff
- the GP practice population provides an essential building block for work on risk stratification, the early identification of people who may be at risk of unplanned use of health services and associated proactive, preventative interventions
- the primary care contribution to dementia care and end of life care pathways
- primary care role as ‘gatekeeper’ and widespread adoption of good practice in referral management

12.6. The CCG is establishing a group for ‘Primary Care Quality and Development’ which will progress the above areas.

12.7. The CCG will also continue to explore the potential for other primary care providers to contribute, particularly to out of hospital pathways e.g. potential greater role for optometrists’ in triage and out of hospital eye care provision; community pharmacists role in integrated working around both high risk patients and those who will benefit from support with management of their long term condition(s).

13. People with Learning Disabilities (PLD)

13.1. The CCG continues to commission services for people with learning disabilities jointly with RBK. We are jointly progressing discussions progressing around lead commissioner arrangements, need/approach to service review and the potential for pooled budgeting.

13.2. The CCG remains committed to working with the LD Parliament to co-produce a specification for PLD health services which includes local primary, community, secondary and specialist mental health services. As has been previously stated we expect that the specification will address requirements around annual health checks, health action plans, hospital passports and specialist services.

13.3. Some points regarding provision in general practice and the annual health check were raised at a recent presentation to the CCG’s Council of Members. Although the CCG doesn’t commission these core elements of general practice we will work with Members to address.

14. Medicines optimisation

14.1. Introduction and approach - NHS Kingston CCG aims to support effective medicines optimisation for people in Kingston, helping people to get the most out of their medicines. Medicines optimisation requires health and social care professionals, patients and carers to work in an integrated model of care to support people closer to where they live.

The medicines optimisation commissioning intentions and QIPP plan for 2014-15 build on existing work to drive improvements in quality and efficiency through effective medicines use. Joint initiatives across Kingston include the establishment of a joint formulary process with Kingston Hospital Foundation Trust and South West London and St George’s Mental Health Trust and joint medicines optimisation projects with the Local authority. The aim for this year is to improve the implementation of
Key Performance Indicators with Kingston Hospital where success is dependent on joint working. The Primary Care Prescribing Budget efficiency savings for 2014-15 will be delivered through an annual prescribing work plan that will incorporate National Institute of Clinical Excellence (NICE) and patient safety guidance, and National Quality, Innovation, Productivity and Prevention (QIPP) Indicators.

Effective delivery of the QIPP plan is dependent on the CCG medicines team engaging within the Clinical Commissioning Group and GP practices in Kingston to identify local priorities and ensure where appropriate, any local work is supported by engagement with secondary care colleagues.

Clinicians across all providers will be expected to prescribe in line with the Kingston Joint Medicines Formulary & Medicines Committee guidance and to proactively engage with the economy wide processes for the management of new entry of New Drugs and NICE Implementation.

In 2014/15 Kingston CCG medicines team plans to:

14.2. Primary Care

- Further improve prescribing efficiency and the uptake of medicines optimisation initiatives in primary care through the investment in a Medicines Management Incentive Scheme.
- Further support the reduction of inappropriate variations in GP prescribing practice.
- Deliver improvements in area wide medicines management priorities such as respiratory medicine.
- Continue with procurement of software that increases the percentage of more cost effective prescribing choices and review electronic systems that reduce the risk of hospital emergency admissions.

14.3. Social, Mental and Community Care Services

- Continuation and expansion of joint projects to improve medicines safety optimisation in care homes.

14.4. Your Healthcare Community (YHC) Services

- Joint working with community teams on medicines optimisation and initiatives to support improvement in the quality and cost effectiveness of prescribing products for wound care, stoma and catheter devices.
- Work with Your Health Prescribers to support the uptake of health economy wide formularies and CCG Medicines Guidance.

14.5. Kingston Hospital Foundation Trust (KHFT)

- Better medicines commissioning within service redesign and pathway development
- Improve the implementation of Key Performance Indicators with Kingston Hospital to support the Primary Care prescribing QIPP.
- Implement processes to further improve the optimisation of secondary care medicines excluded from the Payment by Results (PBR) Tariff (via the Commissioning support unit).

14.6. South West London & St Georges Mental Health Trust (SWLSGH)

- Implement health economy wide strategies to support the Primary Care prescribing QIPP.
- Further improve the development of a joint formulary processes and shared care guidelines with local providers
- Support providers to improve systems to support safe transfer of information on patient medication at admission and discharge.
15. Quality

- The CCG will ensure that the themes and recommendations Francis Inquiry are at the heart of its commissioning activities. Important elements of this are:
  - The CCG provides Clinical Chairs for the Clinical Quality Review Groups (CQRG) for Kingston Hospital NHS FT, Your Healthcare CIC and SW London and St George’s Mental Health Trust. The CQRGs routinely review formally reported quality indicators. ‘Softer’ quality information is also considered, including quality issues raised by patients and referrers. Whether issues arise through formal or more ad-hoc routes, providers are asked to develop responses which may be in the form of action plans. The CQRGs monitor the resulting change and impact and also link with other performance management arrangements for the providers’ contracts. This approach helps to ensure that clinical and patient perspectives remain central in the CCG’s commissioning efforts.
  - The CCG’s Integrated Governance Committee is working to integrate intelligence and narrative to inform safety, clinical effectiveness and patient experience.

- The CCG will continue to seek service user feedback about service quality, using a variety of mechanisms, to inform performance management, shaping and commissioning services for the future

16. Other service items

16.1. Promotion and prevention

- Providers will be expected to commit to Kingston CCG’s ethos of make ‘every contact count’ in terms of encouraging patients to adopt healthier lifestyles and providing opportunities for them to do so (for Kingston Hospital NHS Foundation Trust this includes continuing work to become a Health Promoting Hospital). This extends to being an employer that does the same for their staff and the staff employed by the companies they contract with. This should include a requirement to become truly Smokefree.

- Providers will ensure opportunities for patients to be referred to health promotion and prevention programmes to reduce the burden of their disease or their lifestyle on their long-term health are maximised. Priority areas include:
  - Smokers motivated to quit are referred to the specialist stop smoking service by deploying ‘Ask, Advise, Act’ principles of brief interventions
  - Patients consuming alcohol above the recommended limits can be referred to specialist services or the e-drink- check@kingston.org.uk web based service. This will require screening of alcohol intake of patients
  - Referral to the Healthy Lifestyle Programme for patients motivated to increase their physical activity or lose weight
  - Referral to the Kingston Wellbeing Service for patients with mild to moderate anxiety and depression

16.2. Non acute

- proposed development areas for 2014/15 associated with improving choice and outcomes by shifting care settings (e.g. secondary to community) and pathway development, including:
  - commission a community cardiology service
  - commission an intermediate gynaecology service
• consider whether changes are required to the community dietetic service to fulfil the requirements of NICE guidance re bariatric surgery – if there are financial implications they will have to go through established CCG processes around prioritisation and business case development
• continued support for joint primary care / Your Healthcare CIC musculoskeletal physiotherapy pathway changes introduced in 2013/14
• consider – are there any issues with paediatric speech and language therapy e.g. linked to Children and Young People’s workstream, changes in statementing and potential offer of personal budgets and personal health budgets

16.3. Acute

• From the Cancer Commissioning Intentions ‘CCGs should increase investment in endoscopy services to meet the growing demand driven by the best practice commissioning pathway for the earlier detection of colorectal cancer’ - Kingston Hospital will need to achieve JAG accreditation for endoscopy provision to meet item 3 in the cancer commissioning intentions (section 9)
• Bariatric surgery – Kingston CCG will be working with other SW London CCGs, led by Wandsworth CCG, to consider procurement of a Tier 3 service across the area
• Kingston Hospital has identified a number of potential development areas for 2014/15 linked to the CCG’s strategic workstreams which will form part of discussions leading up to the new financial year:
  – Children & Young People - Paediatric Allergy Clinic; Joint clinics for Paediatric Gastroenterology, Paediatric Intermittent Catheterisation Clinic; Paediatric Virtual e-mail clinic; Fetal Medicine – Amniocentesis; Fetal Medicine - Chorionic Villus Sampling
  – Integrated Care - Cataract post-op follow up pathway; Pain and musculoskeletal pathways for management of pain across Primary and Secondary Care [involves orthopaedics + pain + rheumatology services]; Review of Radiology pathways and tariffs; Review of Cardiac pathways; Review of Phlebotomy pathway; Review of Gynaecology pathway; Occupational Therapy splinting and advice for patients with Rheumatoid Arthritis; Additional St George’s activity - KHFT to take on additional activity under Urology / Gynaecology / Upper GI on behalf of SGH
  – Older people & People with Long Term Conditions - Mature Age Related Macular Degeneration pathway - local Optometrists pilot; Pathways for Diabetic Macular Oedema (DMO) and Retinal Vein Occlusion (RVO); Review of Diabetes pathway; Older People’s Psychiatric Liaison Service (to be held at KHFT - tri-partite funding K,R&S CCGs); Parkinson's Disease nurse specialist
  – Unscheduled Care – Acute care physician pilot

17. Prescribed specialised services

NHS England has described their commissioning intentions and rationale in the 2/10/13 publication ‘Prescribed Specialised Services Commissioning Intentions 2014/15-2015/16’. This includes:

‘At a clinical level, major changes in the scope of services directly commissioned by NHS England are not intended for 2014/15, as we believe a period of stability is required after the major changes in 2013/14. The technical algorithm to align services between NHS England and Clinical Commissioning Groups’ (CCGs) commissioner responsibility, “The Identification Rules”(IR), has been refined to improve its precision and will be further updated to align to the update of procedure codes for all NHS services. A summary of the impact of the Information Rules refinement will be provided in the coming weeks to aid forward planning by trusts and commissioners.’
In addition to a range of technical guidance the above document makes specific reference to the following clinical service areas:

- Mental Health
- Innovative Radiotherapy
- Paediatric Cardiology
- Genetics
- Haemophilia
- PET / CT

18. London Ambulance Service

Draft Commissioning Intentions for London Ambulance Service (LAS) 2014/15 have been developed by the lead commissioner NW London Commissioning Support Unit. In addition to modernisation, high performance against ambulance clinical quality indicators and contribution to system-wide cost reduction, the key commissioning priorities identified are:

1. LAS implementation of a revised model of care, optimising use of resources and clinical outcomes, responding to the ‘Capacity Modelling Review’ undertaken jointly with commissioners in 2012/13, through:
   a) Increased appropriate levels of Hear & Treat, utilising the benefits of 111, Directory of Service and continued implementation and development of NHS Pathways
   b) Increased appropriate levels of ‘See & Treat’ and ‘See and Refer’ (to other non acute services)
   c) Enabling workforce transformation, with appropriate skill mix and tasking

2. Consistent timely Red 1 and Red 2 performance, for potentially life-threatened patients, regardless of season, time of day or location in London, through:
   a) Full implementation of predictive capacity and workforce tool
   b) Optimised tasking of ambulances (e.g. reduction in multiple vehicle attendance)
   c) Workforce alignment (rosters, skill mix, annual leave, rest breaks etc)

3. Specific focus on Demand Management and fundamentally aligning LAS resources and systems, to enable the wider system to be able to:
   a) Identify frequent callers/locations, and develop appropriate plans
   b) Evidence to identify the need for appropriate alternative care provision
   c) Tackle specific demand areas - Police, Public Transport, Alcohol, and Care Home referrals

4. Strengthening clinical outcomes for patients across all care pathways,
   a) Provision of patient level information (incl. NHS Number) to enable decision making by clinicians across the healthcare system
   b) Working with each Clinical Commissioning Group to support QIPP plans
   c) Patient and public engagement and involvement in pathway development

The above priorities are underpinned by the CQUIN framework; proposed schemes are currently being developed by CCGs, in partnership with LAS.

19. Quality, Innovation, Productivity and Prevention Programme (QIPP Programme)

The CCG’s QIPP programme for 2014/15 will once again aim to release funds through efficiency improvements or decommissioning for reinvestment to (i) improve quality or (ii) address pressures in the system as described in section 6.3. There will be an emphasis on change and development to

- reduce people’s unplanned use of health services
- ensure that planned use of services is evidence based and increasingly consistent across the CCG’s area
• optimise pathways for effectiveness, efficiency and patient experience
• increase prevention e.g. through improved access to diagnostic services enabling earlier intervention
• increase patient awareness and self-management
## Appendix 1  Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>AAA</td>
<td>Abdominal Aortic Aneurysm</td>
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<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>AQP</td>
<td>Any Qualified Provider</td>
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<td>ASC</td>
<td>Adult Social Care</td>
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<td>ASD</td>
<td>Autistic Spectrum Disorders</td>
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<td>BME</td>
<td>Black and Minority Ethnic</td>
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<td>BSBV</td>
<td>Better Services Better Value</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CDAT</td>
<td>Community Drug and Alcohol Team</td>
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<td>CHCB</td>
<td>Children's Health Commissioning Board</td>
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<td>CHD</td>
<td>Coronary Heart Disease</td>
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<td>CI</td>
<td>Commissioning Intentions</td>
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<td>CIC</td>
<td>Community Interest Company</td>
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<td>CMC</td>
<td>Coordinate My Care</td>
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<td>CMHT</td>
<td>Community Mental Health Team</td>
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<td>CNRS</td>
<td>Community Neurological Rehabilitation Service</td>
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<td>CQRG</td>
<td>Clinical Quality Review Group</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<td>CSP</td>
<td>Commissioning Strategy Plan</td>
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<td>CSU</td>
<td>Commissioning Support Unit</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DP</td>
<td>Direct Payment</td>
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<td>ECET</td>
<td>Equalities and Community Engagement Team</td>
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<td>ECI</td>
<td>Effective Commissioning Initiative</td>
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<td>EHC</td>
<td>Education Healthcare Plan</td>
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<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<td>EoLC</td>
<td>End of Life Care</td>
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<td>ESD</td>
<td>Early Supported Discharge</td>
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<td>FT</td>
<td>Foundation Trust</td>
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<td>GPwSI</td>
<td>GP with Specialist Interest</td>
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<td>HASU</td>
<td>Hyper Acute Stroke Unit</td>
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<td>HWB</td>
<td>Health and Wellbeing Board</td>
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<tr>
<td>HWS</td>
<td>Health and Wellbeing Strategy</td>
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<tr>
<td>IAPT</td>
<td>Increased Access to Psychological Therapies</td>
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<tr>
<td>ITF</td>
<td>Integration Transformation Fund</td>
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<tr>
<td>JAG</td>
<td>Joint Advisory Group (on gastrointestinal endoscopy)</td>
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<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>KCAS</td>
<td>Kingston Clinical Assessment Service</td>
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<tr>
<td>KCCG</td>
<td>Kingston Clinical Commissioning Group</td>
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<td>KCI</td>
<td>Kingston Co-operative Initiative</td>
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<td>KHFT</td>
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<td>KHT</td>
<td>Kingston Hospital Foundation Trust</td>
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<tr>
<td>KISH</td>
<td>Kingston Integrated Sexual Health Network</td>
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<tr>
<td>KPI</td>
<td>KPI Key Performance Indicator</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LAS</td>
<td>London Ambulance Service</td>
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<td>LCP</td>
<td>London Cancer Programme</td>
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<td>LCS</td>
<td>Locally Commissioned Services</td>
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<tr>
<td>LD</td>
<td>Learning Disability</td>
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<tr>
<td>LES</td>
<td>Local Enhanced Service</td>
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<td>LPP</td>
<td>London Procurement Partnership</td>
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<td>LQS</td>
<td>London Quality Standards</td>
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<td>LSCG</td>
<td>London Specialist Commissioning Group</td>
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<td>LTC</td>
<td>Long Term Condition</td>
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<tr>
<td>MDT</td>
<td>Multi-disciplinary Team</td>
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<tr>
<td>MH</td>
<td>Mental health</td>
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<tr>
<td>MHC</td>
<td>Mental Health in Co-production</td>
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<tr>
<td>MSK</td>
<td>Musculoskeletal</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>OPMH</td>
<td>Older Peoples Mental Health</td>
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<tr>
<td>PB</td>
<td>Personal Budget</td>
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<tr>
<td>P6R</td>
<td>Payment by Results</td>
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<tr>
<td>PH</td>
<td>Public Health</td>
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<tr>
<td>PHB</td>
<td>Personal Health Budget</td>
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<tr>
<td>PLD</td>
<td>People with Learning Disability</td>
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<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
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<tr>
<td>RBK</td>
<td>Royal Borough of Kingston</td>
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<tr>
<td>SDIP</td>
<td>Service Development and Improvement Plan</td>
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<td>SL</td>
<td>South London</td>
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<td>SPA</td>
<td>Single Point of Access</td>
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<td>SUN</td>
<td>Service Users Network</td>
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<td>SWL</td>
<td>South West London</td>
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<tr>
<td>SWLSGH</td>
<td>South West London and St George’s Mental Health Trust</td>
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<tr>
<td>T&amp;O</td>
<td>Trauma and Orthopaedic</td>
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<tr>
<td>TCSL</td>
<td>Transforming Cancer Services for London</td>
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<td>YHC</td>
<td>Your Healthcare Community Interest Company (CIC)</td>
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## Appendix 2 Useful Documents and Links

### Kingston’s Health

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### Quality

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### A Call To Action

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### Integration Transformation Fund

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<td>xii</td>
<td>Next Steps on implementing the Integration Transformation Fund – letter 17/10/13</td>
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