NHS
Lambeth
Clinical Commissioning Group

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Dear Matthew & Tyrrell

RE: Draft Commissioning Intentions for discussion with Provider Group

Further to our discussions at the Sponsor Board, the Integrated Commissioning Group has drafted a paper setting out key priorities for next year. This is as requested to help provide a focus for the work of the provider group over the next few months. We thought it might be helpful to introduce this to the group this week and Paul Jenkins is able to this if helpful? At the Sponsor Board we discussed the idea of a joint agreement or Memorandum of Understanding and it may be that this document could form the starting point for this?

As you will only just have seen the paper and will need some time to discuss as a group, we propose asking the group for a formal response back to the Integrated Commissioning Group by 31 January to feed into our early February meeting of commissioners.

Yours sincerely,

Dr Adrian McLachlan
Chair

Joint Commissioning Intentions for Health and Care Services in Southwark and Lambeth – 2015/16

1 Our strategic ambition

In order to achieve system wide change we need to begin to behave as one integrated system operating together with one budget. To that end, our aspiration is to contract with a formal alliance of providers from 2016/17.

Recognising that historically we have held organisation specific contracts, in 2015/16, a year of transition, we will continue to hold contracts in the same form. However, to take steps towards our intention of a single alliance contract in 2016/17, we will in 2015/16 seek to harmonise our various contracts so that each is aligned around a shared set of measures. These will be explicit in all of our provider contracts, unifying the system around a common set of outcomes for our citizens. Through our joint commissioning endeavours we expect providers will align and work together in order to deliver pathways of care with developed outcomes-based measures.

2 2015/16 joint commissioning intentions

2.1 Commissioning services that exhibit our desired 'Attributes of Care'

As commissioners will not specify new pathway details, but we will set out the attributes of care we expect to see, and the outcomes we have been asked to achieve by our citizens. We expect to see services that:

- empower and activate people and communities, enabling people to be in control of their health and wellbeing;
- offer holistic and co-ordinated care and support; and
- are proactive, preventative and focused on better outcomes. (Annex

1 sets out the attributes of care in full)

2.2 Commissioning services that deliver the outcomes our citizens want

Over the past twelve months we have engaged with citizens, commissioners and some of those delivering local services in Lambeth and Southwark. Together we have identified a range of priority outcomes to be included in all contracts for 2015/16. These outcomes are new, but they make use of existing measures; it is our intention to make the process as streamlined as possible limiting the burden of reporting.

Outcome	Available (sample) data	Other suggested measures for future development
Deliver a sustained and managed reduction in emergency admissions to hospital	Better Care Fund trajectories – 3.5% for Southwark and 2% for Lambeth	Time spent at home (NHS number linked to SUS or HES)
I have systems in place to help at an early stage to avoid crisis and as small a disruption as possible if a crisis happens and "I live independently?" (citizen and commissioner prioritised)	Emergency admissions And residential care	
I can manage my own *health and wellbeing (or condition)* and *I am supported* to do this (including having access to information and being able to stay healthy) (citizen and commissioner prioritised)	GP survey (able to manage own condition) And QOF health behaviour measures or CQUIN measures	Patient activation recorded as part of routine GP care
I can plan my care with people who work together to understand *me* allow me control and bring together services to achieve the outcomes that are important to me (citizen prioritised)	Patient experience composite (holistic health assessment uptake could be an alternative activity measure)	Validated measures for integrated care (in development nationally)
Citizens and carers - I *(am able to)* live the life I want *(and get the support I need to do that)* (citizen prioritised)	Health related quality of life (GP survey) Carer related quality of life (carers' survey)	Wellbeing (Warwick Edinburgh Mental Wellbeing Scale - SWEMWBS?)
I feel (am) *safe, secure and protected from harm* (citizen prioritised)	Social care survey (plus other measurement to be developed)	

2.3 Specific areas of focus

Recognising that this is a new partnership and a new approach to commissioning for our populations, commissioners would like to see providers focusing on a range of specific opportunities for improving the delivery and co-ordination of services in 2015/16. Providers should:

Adopt services which support people, particularly those at risk, to stay well

- Work together towards delivering population health management, using tools such as risk stratification, holistic assessments and individual care plans and case management for people with, or at risk of developing, long term conditions and mental illness. This approach should promote health and wellbeing by improving

primary and secondary prevention (e.g. improved hypertension management and medicines and other treatment optimisation).

- Improve self-management and self-care as part of quality improvement activities by working with professionals (e.g. improving collaborative communication), individuals and their carers (e.g. education programmes in diabetes, pulmonary rehabilitation and cardiac rehabilitation) and working across organisations to develop the necessary culture and information for people and carers.
- Actively develop relationships (e.g. with the voluntary sector) to make use of available preventative services which address wider social determinants of health and wellbeing, such as social isolation for individuals and their carers

Put in place a range of integrated services to provide appropriate urgent care, reduce avoidable admissions and reduce delays in discharge or onward referral following episodes of inpatient care

- Work to develop and implement a range of ambulatory care pathways as an alternative to emergency admission. This will include mainstreaming approaches that are currently being tested for people with dementia and delirium, poor nutrition, at risk of falls and with continence problems or developing a case for change for new areas.
- Demonstrate services will be appropriately responsive and accessible 7 days a week. In 2015/16 this will mainstream current work on hospital 7 day working and primary care access, where benefits have been demonstrated through testing.
- Support people at home as the preferred option, optimising use of admissions avoidance schemes and reablement to prevent admission to hospital and care homes, with an increased number of people remaining at home following discharge.
- Develop a unified point of access across health and social care to support discharge from hospital and in the community and explore options for further integration.
- Improve end of life pathways so that people receive appropriate care in a setting that is consistent with the person's wishes, and those of their family, and that they are cared for with kindness, dignity and respect.

Put in place conditions which enable providers to integrate care services

- Work together as multi-disciplinary teams shaped around defined local care networks including providers of home care and care homes and the voluntary sector
- Further develop the sharing of information between teams and with individuals and their carers. To extend KHP Online to GP surgeries during 2015/16, test links to social care, community services and community pharmacies. Social work teams to increase population of records with NHS numbers to support integrated information. To further develop access to records for people and their carers.
- Work together to identify how behaviours and functions may need to change for integration to be visible and recognised to individuals, carers and staff
- Develop the decision making processes and guidelines which unify the integrated system around a common set of outcomes for individuals and their carers

3 Process to develop population and outcomes based contracting:

In forthcoming contract discussions we will seek to agree with providers specific actions for 2015/16 that will help the system – through 'shadow form' budgeting and performance management – to build, test and deliver new ways of population and outcomes based contracting. These actions will form the basis of a coordinated and collaborative transition towards a formal alliance arrangement in 2016/17.

We invite providers to consider these joint commissioning intentions and to provide a formal and collective response, mediated through the SLIC Provider Group, by the end of January.

Following a response from the Provider Group, commissioners will seek to produce a Memorandum of Understanding between commissioners and providers collectively; and we anticipate that providers might wish to produce something similar between themselves.

Annex 1: Attributes of care

Annex 2: Prioritised outcomes for further in-year development and for 2016/17 contracting

Prioritised outcome statements	Available (sample) data	Prioritised indicator areas (long term)	Other suggested measures for future development	Who could measure in the future?
Overarching outcomes prioritised by citizens				
For all citizens: I (am able to) live the life I want (and get the support I need to do that)	SWEMWBS (residents' survey) Or health related quality of life for people with long term conditions (GP survey) Or social care related quality of life for people in receipt of social care (ASC survey) Or employment gap for those with LTCs (PHOF)	- Wellbeing (many of the other outcome statements relate to this) - Citizens keen to recognise indicators relating to wider factors that affect our wellbeing (including employment, poverty, environment, social integration)	**NEW MEASURE** Wellbeing of those aged 65+ and those with long term condition (SWEMWBS – 7 or 14 item positively worded validated scale with 1-5 rating of each option) see footnote OR Older Persons Quality of Life (OPQOL), footnote [1] But recognise other outcomes are also related to this	GP-based survey?
For carers specifically: I (am able to) live the life I want (and get the support I need to do that)	Carer SWENWBS (residents' survey) Or carere related quality of life (carers' survey) Or proportion of carers not in paid employment because of caring responsibilities (PHOF)	- Wellbeing (many of the other outcome statements relate to this) - Wider factors that affect our wellbeing (including employment, poverty, environment, social integration)	**NEW MEASURE** Wellbeing - see above But recognise other outcomes are also related to this	GP-based survey?
Other outcomes prioritised by citizens				
I can manage my own health and wellbeing and I am supported to do this (including having access to information and being able to stay healthy)	GP survey (able to manage own condition) And QOF health behaviour measures or CQIN measures	- Patient activation[2] (skills, knowledge and confidence to manage own health) - Smoking, physical activity, diet, harmful/hazardous alcohol	**NEW MEASURE** Patient activation **EXISTING MEASURES** QOF measures for health behaviours CQIN measures	GPs as part of routine long term condition care? GP-based survey for wider population? Social care to inform care and support?
For all citizens: I have as much social contact / (social support) as I would like / I feel part of a community	Proportion of social care users who have as much social contact as they want (ASC survey)	Validated measures available[3] or included in OPQOL but no clear priority from: - I am not lonely	**NEW MEASURE:** Need to select dimension to measure from previous	GP-based survey?

[1] Available at http://www.ilcuk.org.uk/index.php/publications/publication_details/good_neighbours_measuring_quality_of_life_in_old_age

[2] Available at http://www.healthscotland.com/uploads/documents/14092-SWEMWBSSept2007.pdf

[3] Available at http://campaigntoendloneliness.org/toolkit/wp-content/uploads/Scales-for-measuring-loneliness-and-isolation-2.pdf

		- Having as much social contact as I would like - I feel supported		
For carers specifically: I have as much social contact / (social support) as I would like / I feel part of a community	Proportion of carers who have as much social contact as they want (carers' survey)	Validated measures available but no clear priority from: - I am not lonely - Having as much social contact as I would like - I feel supported	**NEW MEASURE:** Need to select dimension to measure from previous	GP-based survey?
Additional outcomes suggested by citizens (lower priority) and commissioners				
I can plan my care with people who work together to understand me and my carer, allow me control and bring together services to achieve the outcomes important to me	Patient experience composite (holistic health assessment uptake could be an alternative activity measure)	This requires more work – a composite of patient/service user satisfaction measures could be used in the short term: - NHS friends and family - Acute trust real time measures - Social care satisfaction (not currently collected from all) - GP satisfaction	Not yet known	Every contact with every provider?
I feel (am) safe, secure and protected from harm	Social care survey To be further developed		Would help to offset any perverse incentives from 'time spent at home' or 'emergency admissions' measures	Every contact with every provider?
I feel (am) respected, my dignity is maintained, and I do not experience any discrimination or harassment	Not yet known		Would help to offset any perverse incentives from 'time spent at home' or 'emergency admissions' measures	Every contact with every provider?
I have systems in place to help at an early stage to avoid crisis and as small a disruption as possible if a crisis happens	Emergency admissions And permanent residential care admissions	Time spent at home?	**NEW MEASURE** Data could be linked by HSCIC through the CSU but this may have funding implications **EXISTING MEASURES** Proportion of people still at usual place of residence 91 days after hospital discharge (limited in population coverage as only those with an admission)	Commissioners (from existing primary care and acute trust data linkage)
Quality measure related to staff satisfaction or turnover	Not yet known		Not yet known	Every provider
I can live independently, with assistance if necessary	Permanent residential and care admissions	Time spent at home?	**EXISTING MEASURES** Social care data for admissions **NEW MEASURE** Time spent at home	Commissioners
I have control	Not yet known		Not yet known	Not yet known