Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Clinical Commissioning Programmes**
Report of	Chief Officer, Barnet Clinical Commissioning Group
Summary of item and decision being sought	This paper provides an update on Clinical Commissioning Programmes in Barnet, for information

Officer Contributors	John Morton, Chief Officer, Barnet CCG
Reason for Report	This paper provides an update on Clinical Commissioning Programmes in Barnet, for information
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	John Morton, Chief Officer, Barnet CCG, John.Morton@barnetccg.nhs.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes this report for information.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The Clinical Commissioning Programmes proposals have been considered and approved by the Barnet CCG Governing Body.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 The Clinical Commissioning Programmes Terms of Reference allow for engagement with strategic partners.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Each Clinical Commissioning Programme and projects arising therefrom will consider the requirement for needs assessment and equalities impact assessments.

5. RISK MANAGEMENT

5.1 Risks identified within the plan will be managed through the Barnet Clinical Commissioning Group Board Assurance Framework and Risk Register.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 The Clinical Commissioning Programmes will make a significant contribution to managing local NHS finances.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Each Clinical Commissioning Programme project will consider communication and engagement with users and partners.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Each Clinical Commissioning Programme project will consider membership from providers and communication and engagement with providers.

10. DETAIL

10.1 Summary

10.2 The PCT`s work was largely driven by the productivity elements of QIPP and the CCG are determined to ensure we deliver quality and innovation which will in turn drive

productivity. The CCG are moving to a Clinical Commissioning Programme (CCP) delivery model which covers comprehensively the range of services we commission. These are clinically and managerially led with each CCP supported by a GP Board member as clinical strategic lead, a senior manager and project management team. The two directors of commissioning (Integration and Clinical) will support the six CCPs.

10.3 Each CCP will, working with partners, providers, the local authority, patients and the public, review the needs assessments, current service delivery and outcomes in order to decide which services within each portfolio need to be reviewed and in what priority. These will form the projects to be delivered in year by the project teams. This will encompass the delivery of QIPP and be supported by the project management office (PMO).

10.4 The proposal to develop clinical commissioning programmes sets out a way to ensure our commissioning adequately covers the services that we are responsible for. CCPs need to be grouped in ways which people recognise and, collectively, these need to cover the whole health system which we have responsibility for. However, the health system is complex and each approach taken to dividing up into manageable parts has both advantages and disadvantages.

10.5 The integrated plan and 'plan on a page' set out the strategic priorities for the CCG. In this context there is a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;

- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.

- This will require new ways of working; to provide robust foundation for a rebalanced system, we are restructuring the work of the CCG, and our team, into Clinical Commissioning Programmes (CCPs), which reflect the objectives set out in our plan on a page.

10.6 Introduction

10.7 The CCG is responsible for commissioning population-based general health care services for the registered population. While the CCG does not have direct responsibility for specialist, public health and primary care contracting, we will have a fundamental interest in ensuring these services are commissioned well for our population.

This proposal to develop clinical commissioning programmes sets out a way to ensure our commissioning adequately covers the services that we are responsible for.

10.8 Approach

10.9 CCPs need to be grouped in ways which people recognise and, collectively, these need to cover the whole health system which we have responsibility for. However, the health

system is complex and each approach taken to dividing up into manageable parts has both advantages and disadvantages. These are set out below:

10.10 Organisational Commissioning

The approach to contracting is currently organisational. We contract with different provider organizations based partly on the care groups (Acute, community, mental health, orthopaedics etc.) or on geography (general hospital services from Barnet and Chase Farm and the Royal Free Hospitals), which is largely driven by patient choice. An alternative approach would be to commission on organisational type such as community, mental health and acute. Arguably this is aligned to the current approach which recognises the organisations over the patient and treats the disease in steps rather than in pathways. This has resulted in most patient care spend being on the acute step and less on the primary and community phases.

10.11 Disease Groups

Medicine can generally be divided into disease groups, organic systems, or "Specialities". Examples are cardiovascular (including diabetes and renal), gastroenterology, urology, MSK etc. Setting CCPs up in this way would enable detailed review of each area. However, this requires some generic grouping, I.E mental health, health promotion and prevention etc.) A further weakness of this approach is dealing with cross cutting themes such as emergency care and older people's care which cross all disease groups. This approach can also generate a large number of CCPs, depending on the disease groups.

10.12 Care groups

A further approach may be to consider care groups, or settings of care, with each care group leading on a range of disease groups which largely, but not exclusively, fall within the care group. This would allow the CCPs to work on a sensible grouping of clinical services and relate to specialist clinicians/providers in a manageable way.

Suggested care groups would be as follows:

- Health promotion and prevention
- Children, families and maternity
- Elective acute care/General Surgery
- Urgent acute care/General Medicine
- Long term conditions /Older peoples services
- Mental health including learning disability

10.13 Health promotion and prevention

10.14 The responsibility for commissioning and delivery has moved to the local authority and public health England. However it is recognised that the impact of smoking and obesity on general health is immense. CCGs should be commissioning for every health contact to be a public health contact. This will not be a large CCP as the budgets have moved to Public Health, however, it is recommended that it is an area worth time-specific focus. The CCP would also oversee the CCG relationship with public health.

10.15 Children and Family (Including maternity)

A healthy start in life and emotional health and wellbeing underpin the future health of the population. Barnet CCG will commission children's' services jointly with the local authority and work across physical care and emotional health and wellbeing. As we will want to see close integration between secondary care and community services, this CCP would lead on secondary care children's and maternity commissioning. The CCP will require good partnerships with local authorities, schools, providers and health visitors to 2015 with the national commissioning.

10.16 Elective Acute Care/General Surgery (Arguably to include community out-patient services)/General Surgery

This CCP will work with pathways which most commonly present as planned procedures in a hospital setting. This could include the following planned treatments:

- Orthopaedics (MSK and Pain)
- Urology
- Vascular
- Neurology
- ENT
- Opthalmology

This CCP will require good partnerships with acute and community providers with an emphasis on general surgery and orthopaedics.

10.17 Urgent Acute Care/General Medicine

This group will work in the pathways which most commonly present in an urgent or emergency setting.

There will be strong links and overlap with long term conditions /older people and mental health. This group is differentiated by an immediate or imminent need for assessment, diagnosis and treatment in a way which could not have been planned or predicted. This could include:

- Cardiology, including Diabetes and Renal
- Respiratory
- Gastroenterology
- Trauma

This CCP will lead the emergency and urgent care network and have good partnerships with the urgent care providers (Ambulance, out of hours and 111), acute and community providers and mental health providers.

10.18 Long Term Conditions/ Older Peoples Services

This CCP will lead on integrated care across the health sectors including social care. The CCP will lead on pathways where most of the care will be provided in a community or primary care setting. This will be joint working with the London Borough of Barnet.

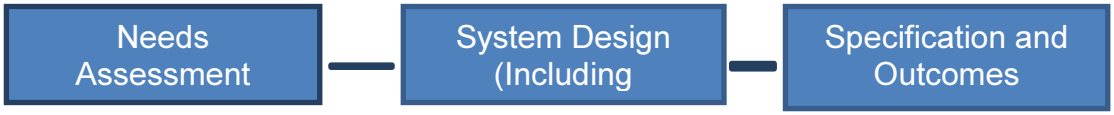
The care service will be based on generic community teams supporting people meeting planned (LTC) and unplanned (Crisis/Step up) care at home or in a community setting. The service design will provide community services which support primary care and work together to support the more complex needs in community settings.

10.19 Mental Health

The CCP will have the brief to develop a commissioning strategy for mental health service and to ensure stronger contract management and procurement so that safe and acceptable mental health services are provided to Barnet residents. This CCP will jointly commission services with the London Borough of Barnet and will work closely with all providers including third sector provision. This is the largest CCP and may require two GP board leads.

10.20 CCP Organisation

10.21 Each CCP will be led by a GP board member (some may have two) and be supported by a senior project manager reporting to a director. The CCP will work on the initial phases of the commissioning cycle.



The CSU will take responsibility for processing, contracting and reviewing projects.

10.22 Each CCP team will be responsible for delivering the relevant projects in each annual operating plan, working with partners and providers. This includes engagement, consultation and impact assessments.

10.23 Whilst it will be for each CCP to determine detailed methodology, it is expected that regular CCP discussions will be held with providers and other stakeholders to shape and progress plans and pathways. The CCP will identify and prioritise projects for implementation in current and future years.

10.24 For 2014/15 and beyond the overall CCG priorities will be set by the CCG members, the CCG governing body, the health and wellbeing board and the public. This will be achieved by considering the CCP programmes and prioritising investment and disinvestment.

10.25 Summary

The proposal sets out a comprehensive approach to commissioning general health services, assessing needs reviewing services and prioritising and implementing changes. The Health and Well-Being Board is asked to note the proposals.

11. BACKGROUND PAPERS

None