NHS WARWICKSHIRE NORTH

CLINICAL COMMISSIONING GROUP

COMMISSIONING INTENTIONS – 2013/14

Date: 28 September 2012

Status: Final

1 ABOUT THIS DOCUMENT

This document sets out the Commissioning Intentions of the Warwickshire North Clinical Commissioning Group that will underpin our contracting requirements for 2013/14, and to take a forward look at the financial years 2014/15 and 2015/16.

It contains the following sections

- **Introduction** – a brief outline of how our commissioning intentions have been developed and how they fit within our development as an organisation
- **Arden Integrated Plan** – outlines the key principles that we and along with other CCGs, providers and local authorities have agreed to work on over the next three years
- **Warwickshire North Clinical Commissioning Group** – an overview of our values, population and the health and wellbeing challenges that we will need to address in Warwickshire North
- **Our Strategic Direction** – outlines our vision and the next steps to developing our strategy
- **Commissioning Principles** – outlines the principles that underpin how financial resources will be deployed to support improvement in the health of the Coventry and Warwickshire populations. Outlines the basis of high level commissioning intentions that will apply to all providers
- **Commissioning Intentions**
    - Outlines our service vision
    - Provides details on the changes we want to be reflected in all 2013/14 acute contracts but we have provided more detail for George Eliot Hospital NHS Trust (GEH) as our main acute provider
    - Details the changes to community services for Warwickshire North that we would like South Warwickshire CCG to secure in the South Warwickshire Foundation Trust 2013/14 contract on our behalf.
    - Outlines the changes to services that we would like the Coventry and Rugby CCG to secure for Mental Health and Learning Disability services in the Coventry and Warwickshire Partnership Trust 2013/14 contract on our behalf.
    - There are a number of other contracts where we are part of a larger consortium of CCGs notably Pathology services, West Midland Ambulance Service and the new 111 service. Our specific requirements are also detailed in this section
- **Contract Timetable** – a high level indication of the deadlines we are going to work to in order to achieve a signed contract by mid-January 2013 as agreed with George Eliot Hospital (final national deadline 31 March 2013.

2 INTRODUCTION

Our commissioning intentions for 2013/14 build on the programme of work outlined in the Arden Integrated Plan and reflect our emergent strategy for Warwickshire North CCG.

These commissioning intentions are intended to provide our providers and partners with a transparent declaration of the CCG direction of travel and priorities that we will be focusing on in 2013/14.

In line with National Policy, the Arden Cluster has delegated the responsibility of developing and implementing the commissioning cycle for 2013/14 to its emerging clinical commissioning groups. Contracts for 2013-14 will be formally signed off by CCG Accountable Officers as well as the Cluster Chief Executive or LAT Managing Director.

Whilst the broad strategic direction that underpins the commissioning intentions is reflective of the strategy outlined within the Arden Integrated Plan, as refreshed in the Spring of 2012, specific commissioning intentions both build on existing QIPP schemes that were established during 2012/13 and reflect new, emergent thinking from clinicians with respect to how services can best be shaped and re-modelled to deliver improved health outcomes whilst securing quality and cost improvements. In line with financial allocations for 13/14, further work will be undertaken to continuously identify and work up in-year QIPP schemes with providers. Whilst the financial challenges are at the forefront of our minds we are also keen that the requirement to reduce cost does not hamper our ability to innovate, improve quality and deliver services differently.

We are expecting more detail to emerge following the publication of the Operating Framework in December 2012. We will need to review these intentions once the requirements of the Commissioning Outcomes Framework become available. We are also expecting more details on the services that will be subject to Any Qualified Provider (AQP).

We want to collaborate with our providers, local authorities and other partners to deliver improved services and better health outcomes for the people of Warwickshire North. This means firstly, making the most of the services that we and local authorities commission. A key requirement of providers this year will be for all providers to evidence the right quality of service and the right quality of transfer of patients from one provider to another. We want patients and carers to experience seamless care and the information accompanying patients to be appropriate, timely, accurate and complete to support the best outcomes and experience.

We believe that QIPP schemes need to be worked on together in order to get the best commitment to implement the change from all parties.

The commissioning intention process has been led by the clinical leaders of Warwickshire North and they have been approved by the CCG Executive. They are based on the priorities identified in the Warwickshire Joint Strategic Needs Assessment and Health and Wellbeing Strategy, national and SHA priorities, QIPP work streams and views of local GP practices, stakeholders, patients and carers.

CCGs will collaborate with one another through the commissioning cycle process to ensure all parties to any contract are appropriately engaged. Contracts for 2013/14 will need to be disaggregated to a consortia level to enable appropriate financial review and management. Public Health components of contracts will need to be clearly identifiable to reflect the future transfer of Public Health commissioning budgets to the Local Authority.

3 ARDEN INTEGRATED PLAN

In April 2012 NHS WNCCG along with health and care partners within Arden signed the Arden Integrated Plan. The plan sets the direction of travel from 2012 to 2015 and therefore our commissioning intentions have been based on the Arden Integrated Plan. This is particularly important in terms of the financial forecast and the requirement for provider reform. We support the Arden Integrated Plan because we believe in the collective vision it articulates and the five priorities outlined below:

- Continue the drive to promote healthy living and lifestyle choices, in particular, through the 'making every contact count' initiative, but in all areas of public health. Maximising the gains to be had from working alongside local authority colleagues whose services impact on people's health and well-being
- Drive up primary care quality and safety, and support GPs to remove unacceptable variation in clinical care in order that they move as near as possible to national upper quartile best practice performance
- Maximise the potential for frail older people to live independently by helping them to self-manage long term conditions where it has not been possible to prevent them; and when older people need intervention, to deliver as much care for them as possible outside of hospital and in a co-ordinated way by all agencies
- Promote well-being in mental health through the delivery of efficient, excellent, services that provide effective person centred clinical outcomes which ensure an exceptional experience is delivered first time and every time
- Deliver best practice in acute hospital care, focussing on optimising 24/7 care for the very sick and acutely ill as a first priority

4 NHS WARWICKSHIRE NORTH CLINICAL COMMISSIONING GROUP

4.1 Our Values

- Quality and Equality first
- Dignity, respect and compassion in the services we commission
- Working together, improving health and securing sustainable services
- Benefiting the whole community, as wasted resources are wasted opportunities for others

4.2 Our Population

In order to understand the challenges and opportunities that the Arden Integrated Plan will provide for the Warwickshire North health and care system we have worked with the Public Health department to identify the Joint Strategic Needs Assessment (JSNA) priorities for South Warwickshire. Our Health and Wellbeing Challenges are as follows:

- **The population of WNCCG is growing -** The rate of population growth is below the County rate with the lowest growth in North Warwickshire. Nuneaton and Bedworth's population grew at 5.1% since 2001. Projections show a predicted overall increase of 7.9% (NWBC) and 12.6% (NBBC) by 2033
- **The population of NWCCG is ageing -** In North Warwickshire the over 65 population is expected to grow by 60% by 2030 (48% Warwickshire). In Nuneaton and Bedworth the growth is projected at 43%.
- **Health Inequalities Persist -** Life expectancy in the north of Warwickshire is lower than the Warwickshire average, in Nuneaton and Bedworth the rates are significantly lower than the England average. There is considerable variation across the area.
- **Educational attainment in the North is significantly below the national Average -** In North Warwickshire the % of pupils achieving 5 A*-C grades was 49% and 52% in Nuneaton and Bedworth, with significant variation across the area. Uptake is lower in those who are entitled to Free School Meals.
- **Economy: Unemployment in Nuneaton and Bedworth is the highest in the County -** In July 2012 the claimant count stood at 2,861 a rate of 3.7% of the resident working age population
- **Improved Access to Services -** The rural nature of North Warwickshire means that some people face problems accessing everyday services such as jobs, education, GP surgeries, shops etc This can be a significant problem for people who do not have their own transport.
- **Long Term Condition disease prevalence/ incidence/ mortality**
    - **Cancer** - Whilst WNCCG has lower cancer incidence, mortality is amongst the highest in Warwickshire particularly in the under 65s. This suggests late detection of cancers. Screening uptake also varies across the area.
    - **Diabetes** - There appears to be higher identification rates and higher numbers of people on diabetes registers in the North, although there is considerable variation across practices

- **Chronic Obstructive Pulmonary Disease (COPD)** - Evidence suggests that diagnosis in Warwickshire North is higher than the Warwickshire and national rate however; data would suggest more than 30% of patients are still not recorded on the COPD registers. There is significant variation across practices. Mortality from respiratory disease is significantly high in North Warwickshire and Nuneaton and Bedworth in persons aged 65-84 years.
- **Coronary Heart Disease (CHD)** - Data suggests a under diagnosis or under recording of CHD in primary care. In addition, mortality from CHD is significantly higher than in England (44.98 rate) for both North Warwickshire and Nuneaton and Bedworth.
- **Stroke** - The ratio of expected to actual numbers recorded on the stroke register is lower than the England and Warwickshire average, suggesting an under diagnosis/recording. There are higher mortality rates for all persons in the North of the County compared to England as a whole.
- **End of Life Care** - In addition to the disease specific issues mentioned above, there are significantly higher levels of patients across Warwickshire North who are dying in their own homes (22.8%) compared to 20.3% nationally and higher rates in Nuneaton and Bedworth dying in hospital (60.3% compared to 54.5 nationally) in hospital. For hospital deaths this relates particularly to CHD across the area all causes of death in Nuneaton

Priorities for upstream interventions and rational

The 2 partnership priorities for Nuneaton and Bedworth and North Warwickshire that have been agreed in consultation with stakeholders across the area are:

- **Rising levels of obesity -** There is a significantly high prevalence of obesity across Warwickshire North when compared to the national average. 27.3% of adults in North Warwickshire and 29% in Nuneaton classified as obese compared to a Warwickshire average of 25% and a national average of 24.2%. In children, measurements of obesity are also above the Warwickshire rate at 8.5% in North Warwickshire and 9.9% in Nuneaton and Bedworth compared to 7.8% in the County. At Year 6 this rises to 19.5% in NW and 17.7% in Nuneaton and Bedworth compare to 16.2% in Warwickshire as a whole.
- **Increasing levels of alcohol related harm -** The rate of alcohol related hospital admissions in North Warwickshire and Nuneaton and Bedworth has seen an overall increase in the last 5 years in both males and females. The rate for males in Nuneaton and Bedworth is significantly above the England average.

In addition, smoking remains priority for the NHS in Warwickshire North:

- **Smoking remains the single biggest preventable killer in the UK -** Across Warwickshire North, more than 22% of adults smoke and in Warwickshire 16.7% of women smoked during pregnancy, with numbers increasing.

We are working very closely with public health, North Warwickshire and Nuneaton and Bedworth Borough councils; and Warwickshire County Council to understand the impact of the projected population growth on the Warwickshire North care system.

4.3 Making every contact and interaction count

WNCCG intends to work closely with public health in Warwickshire to ensure that services which influence public health behavioural change are integrated with those services which WNCCG commission. It is essential that all partners work together to make the most of our available resources and continuously reinforce the healthier lifestyles message. It is envisaged that these services will have clear links with health checks and with all services through 'Making Every Contact Count'.

Warwickshire North CCG is committed to listening to our population – our patients, carers and the public. In order to ensure that this is systematically embedded in everything we do we will develop a strategy of public engagement to ensure that the decisions we make are in the best interests of patients.

The CCG recognises the importance that everyone has to play in the redesign and delivery of services and therefore we are committed to working jointly with partners to reduce inequalities and develop joint strategic planning and joint commissioning where this leads to enhanced benefits to our population.

5 OUR STRATEGIC DIRECTION

We have made a significant amount of progress in determining our direction of travel over the next three years. Much of what we have done is a translation of the Arden Integrated Plan into a language and categorisation that is meaningful for our practices, population and partners.

After consulting with our stakeholder network the clinical leaders of the CCG agreed that our vision should be to:

> "Systematically tackle the pressures within the health and social care system to deliver better outcomes for our people. To do this we will seek to commission in a way that reshapes the patients experience of care pathways from end to end.
>
> Our model for this is to drive for:
>
> Early detection and intervention
>
> Greater support for self management by patients
>
> Truly efficient pathways of care"

Over the autumn we will be engaging stakeholders in order to develop these emerging ideas further. Collectively we will need to consider stopping existing work that is not adding the value we had anticipated; deciding what can wait and prioritising initiatives.

6 COMMISSIONING PRINCIPLES

The following principles underpin how financial resources will be deployed to support improvement in the health of the Coventry and Warwickshire populations.

All of our providers are expected to:

- Work collaboratively with relevant partner organisation to develop integrated service provision where this is beneficial
- Ensure clear accountability for handover and direction between individuals, teams and organisations
- Support improvements in health outcomes
- Be clinically effective
- Be cost effective
- Be aiming to move more provision of care into the community or ambulatory care models to replace traditional inpatient care;
- Promote equitable access
- Be responsive to individual and population needs
- Support patient choice – in respect of provider, location and treatment (as appropriate)
- Be affordable within a finite budget
- Contribute to the Warwickshire Health and Wellbeing Strategy and consider their part in addressing the issues and challenges raised within it

Our providers need to assure us that the interventions on patients when care is transferred from the GP to the provider, are adding value. Most specifically, we expect our providers to adhere to clinical pathways and thresholds. Through clinical discussions we expect to expand the number of pathways and gain agreement on an increased number of clinical thresholds. Where guidelines exist nationally (NICE) or locally these must be adhered to.

Commissioners expect their providers to undertake robust capacity planning across services to ensure capacity reflected final contracted activity levels.

In carrying out their commissioning functions, clinical commissioning groups will:

- Work with their local populations to effectively identify local health needs and commission services from the providers best placed to meet the needs of their patients and population
- Commission services from providers who offer a safe and effective service
- Commission services from providers who can offer best value for money
- Commission services from providers who offer timely access to appropriate services
- Work in partnership with providers to identify further areas for QIPP delivery that promote health outcomes whilst reducing costs for both the commissioner and the provider
- Support providers to work collaboratively with each other and with the commissioners (across Health and Social Care) to improve patient experience and assist in seamless Health and Social Care provision, contributing to QIPP savings

- Work towards ensuring there are agreed service specification, contracts and outcome measures for all commissioned services
- Our providers not only have a role in treating illness but preventing it. We therefore expect that providers will implement a strategy of 'Every Contact Counts'. Every contact should be seen as an opportunity for a public health intervention.

Our providers should ensure that the ethos of 'No Decision About Me Without Me' is demonstrable in all services, and we expect that patients and their families/carers be involved in developing care plans and development of services.

7 COMMISSIONING INTENTIONS

7.1 Service vision

We want to systematically tackle the pressures within the health and social care system to deliver better outcomes for our population. To do this we will seek to commission in a way that reshapes the patients experience of care pathways from end to end.

Mortality

Mortality rates are unacceptably high and this must be tackled. George Eliot Hospital must implement the mortality action plan, the key areas for improvement are:

- Significant improvements in the mortality and crude mortality rates to bring the hospital in line with other peer hospitals
- Focus on leadership – through Medical Director/Deputy Medical Director mortality case note review
- Significant improvement in management of fluid balance
- Monitoring of the Early warning signs and systems and appropriate action
- Evidence of significant improvement in the actions resulting from the notes audit work identifying poor record keeping
- Reduction in the number of wards patients move through during their stay

Warwickshire North CCG has been working with the other CCGs locally to develop the sustainable specialties and frail older people's programme and fully supports the high-level objectives for transformational change set out within the Arden System Plan of: delivering best practice in acute hospital care; and maximising the potential for frail older people to live independently; to be delivered as part of the combined Sustainable Specialties and Frail Older People's transformation programme.

Arden Cluster Sustainable Specialties and Frail Older People's Programme

The scope of this programme, as agreed by the Arden System Board, incorporates the principal medical pathways applicable to people with Long Term Conditions and Frail Older People:

- COPD
- Diabetes
- Heart Failure and Cardio Vascular Disease
- Chronic Neurological Conditions
- Geriatric medicine
- Dementia / organic Mental Health
- Stroke
- End of Life care
- As well as a range of surgical specialties and subspecialties, focussing on both scheduled and unscheduled care.

The methodology for taking forward the combined programme, summarised below, has at its heart strong clinical engagement:

- the identification of key clinical standards (e.g. relevant NICE standards, key recommendations from the Royal Colleges, NCEPOD reports, etc.) and variation in local outcomes (e.g. National Audits, patient satisfaction, treatment outcomes, mortality, etc.);
- engaging the local clinical champions and clinical leaders within Trusts and CCGs to jointly agree those standards most relevant to improving local services and health outcomes and to validate local benchmarking information;
- the agreement of Key Performance Indicators (KPIs) to measure the required service improvement against each standard;
- undertaking a gap analysis of the current position within each locality regarding performance against the agreed standards;
- the development of agreed action plans to address shortfalls in the agreed standards within each locality;
- the development of an informatics dashboard for each pathway, bringing together the data underpinning the metrics for each KPI;
- supporting the development of self-sustaining clinical networks, including Peer Review arrangements;
- Aligning incentives and levers through the contract process (e.g. CQUIN).

The benefits of this approach are as follows:

For the CCG commissioner

- they want to know that they are commissioning services that reflect proven innovation and clinically-driven, standards-based best practice; and
- They want to be assured that CQUIN payments are going to providers that are benefitting from the sharing of learning and expertise about innovation and best practice in an innovation network.

For our providers and multi-disciplinary clinical teams

- To work within and across organisational boundaries in developing and testing innovations and in learning from others to ensure they deliver best practice services.

For patients

- more systematic care;
- improved quality and outcomes; and
- improved effectiveness, safety and experience of care which:
- prevents people from dying prematurely
- enhances quality of life
- helps people recover more quickly from episodes of ill health
- ensures that people have a positive experience of care
- Treats and cares for people in a safe environment and protects them from avoidable harm.

The CCG expects each of its providers to fully support and actively contribute to the Sustainable Specialties and Frail Older People's Programme - both in terms of providing the relevant clinical leadership to help develop the key clinical standards, identify the appropriate KPIs and metrics and establish gap analyses and action plans; and also in engaging in discussions with the CCG commissioner around incorporating these standards and the capture of metrics within 2013/14 contracts for healthcare services.

Emergency and Urgent Care Redesign

The CCG intends to work with stakeholders to commission a redesigned emergency and urgent care system. The aim being to ensure that patient's needs are being met in an emergency through integrated service provision for urgent primary care, minor illnesses/injuries and 999 emergencies.

Elective Care

Warwickshire North CCG intends to commission services and pathways which improve patient experience, remove unwarranted attendances at hospital and reduce resource burden to both commissioners and providers. The CCG intends to work with providers to commission efficient pathways of care to deliver on the 18 week promise, make services as person centred and streamlined as possible - removing any inefficiencies and ensuring effective patient centred handovers between individuals, teams and organisations.

End of life care

Recognising the significant number of patients who die in hospital WNCCG intends on working with providers to identify, manage and care for patients on an end of life care pathway to:

- Improve the experience and quality of patient care
- Enable people to die in their place of choice
- Reduce the number of inappropriate interventions
- Manage and reduce unplanned hospital admissions
- Manage and reduce length of stay
- Improve patient flow
- Provide support to carers

Rehabilitation and connecting with other services

Rehabilitation should pursue to get patients back to levels of quality of life as close as to previous to illness. WNCCG intends on ensuring that patients/clients have a positive outcome in relation to their care as outlined in the NHS Outcomes Framework:

- 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

- The CCG will ensure that all providers adopt the NHS Outcomes Framework along with corresponding outcomes indicators.

WNCCG intends to Improve the quality of care that people receive in residential and nursing homes. Part of this will be having specialist services that can work with homes to care for patients proactively as to avoid instability but also to respond rapidly to assess and advise patients with deteriorating health. The CCG also intends to ensure residential staff have sufficient training and support to enable residents to die in the home rather than in hospital

Warwickshire North CCG wishes to work jointly with providers to develop a range of rehabilitation services to meet the needs of the population. Rehabilitation is a key component of all pathways for long term conditions. It has an established role in pathways for people with cardiac disease and heart failure, chronic lung disease and chronic neurological conditions. Rehabilitation services can support safe, supported and timely discharge from hospital - especially for people with complex needs - reducing hospital length of stay. Other benefits of rehabilitation services include reduced dependency on health and social care support and associated costs and it also delivers significant cost savings through alternative pathways of care and reduced longer term support costs.

Early identification, prevention and best management

An essential component of care for patients with long term conditions is the focus on early identification of long term conditions, self management where appropriate and comprehensive care planning. WNCCG would like to work together with partners to review the long term conditions pathways across the area to ensure that the provision of coordinated, integrated care across hospital, community, primary care and social services. The aim being to avoid unnecessary admissions, achieve reduced lengths of stay (LOS) whilst maintaining or improving the quality of care that patients receive.

Though the ambulatory care team, the CCG would like to see the development of phone advice and hot clinics in order to prevent admissions and treat those patients suffering with exacerbations of chronic illnesses, for instance; COPD, earlier.

Mental Health And Learning Disability Services

Warwickshire North CCG has worked with the other Arden CCG's and CWPT clinicians to develop a portfolio of services that:

- Are focussed on recovery and revolve around users being supported to develop services in response to their needs, encouraging users to take more control and utilise personal health and/or social care budgets. These will be people-centred and primary care/ community based and focussed;
- Are formed from commissioning judgements based on best information and evidence requiring both transparency and detail: around how services, staff and skills are deployed; outputs and outcomes realised; as well as practice specific patient level detail covering all stages of peoples' experience of interventions and service provision i.e. knowing what is being commissioned / purchased in detail to enable quality improvement, public accountability and ensure value for money;
- In addition to the above WNCCG would like to ensure that
    - The integrated acute liaison service is fully implemented with our providers and that acute providers ensure that staff are appropriately trained to respond in an

appropriate and sensitive way to people with suspected mental health needs and be able to make appropriate referrals to the Integrated Acute (psychiatric) Liaison services.

- The number of alcohol related admissions is reduced and intends to review alcohol related admissions and explore means of extending multi-agency strategies and pathways
- Patients with dementia are identified early and that early intervention and support is provided to slow the rate of memory loss and hence the period of time for which intensive, often residential, support is required
- Reasonable adjustments are in place to accommodate the health needs of people with learning disabilities accessing acute care. Building on the evidence from national review and direction about the particular health risks and issues impacting on people's experience and outcomes of health services.

Children and maternity

WNCCG recognises the importance of the early years of childhood and welcomes the investment in Health Visiting. The CCG wishes to ensure that this resource is directed in the areas of greatest need to ensure that interventions support long term health outcomes for our population. The CCG believes that Children and Young People need holistic care that meets their needs and will work jointly with partners and providers to ensure that children, young people, their advocates and carers are involved in their care planning to ensure that care is centred around the child/young person.

We will commission services that ensure that when children have complex care needs that their care is provided in a seamless way to ensure that children are able to live as full and independent life as possible. WNCCG fully supports the transfer of paediatric inpatient services to UHCW, with all other services remaining at GEH alongside a newly established 16-hour short stay paediatric assessment unit (SSPAU).

The CCG is committed to ensuring that the transition from Children's to Adult services is integrated across Providers to support young people in the Transition to adult services.

In terms of maternity, the CCG wishes to see a reduction in C-Section rates and an improvement IUGR inter uterine growth restriction screening detection to reduce the number of still birth babies in line with the national average.

7.2 CQUIN

It is anticipated that as in 2012-13, the majority of CQUIN schemes will support the implementation of agreed QIPP initiatives.

7.3 Economy wide performance metrics

The intention of WNCCG is to work with partners in the Local Health Economy to develop a set of performance/efficiency metrics that can be used to demonstrate collective progress towards the

vision and objectives set out in the Arden Integrated Plan. It is anticipated that these metrics will be reviewed via the Warwickshire North CCG Commissioning Sub-Committee.

7.4 Any Qualified Provider

There is an expectation that Commissioners will continue to increase patient choice in local services via the Any Qualified Provider (AQP) route during 2013-14. Providers will be expected to work with Commissioners to identify services where AQP could be beneficial to patients and engage with the Commissioner s during any consultation phases prior to the qualification process.

As at September 2012, WNCCG has no specific plans to extend AQP beyond its current scope: certain elective procedures, direct access diagnostics, adult hearing services, nail surgery, and children's' wheelchair services. Further plans may emerge or be directed. WNCCG will endeavour to share information with Providers who maybe affected by AQP in as timely manner as possible. Appropriate notice for a variation in service will be given by the commissioners for any services moving to AQP.

7.5 Specific Commissioning Intentions: George Eliot Hospital NHS Trust

Mortality

George Eliot Hospital must implement the mortality action plan, the key areas for improvement are:

- Significant improvements in the mortality and crude mortality rates to bring the hospital in line with other peer hospitals
- Focus on leadership – through Medical Director/Deputy Medical Director mortality case note review
- Significant improvement in management of fluid balance
- Monitoring of the Early warning signs and systems and appropriate action
- Evidence of significant improvement in the actions resulting from the notes audit work identifying poor record keeping
- Reduction in the number of wards patients move through during their stay

Patient experience and quality of care

- **No decision about me, without me** - Providers are expected to embrace the national policy and to ensure that all their clinical processes support informed patient choice and decision making.
- **Making every contact count** - Key public health messages to be conveyed at each contact with patients
- **Avoidable harm** - To avoid the number of pressure ulcers, Health Care Acquired Infections, falls and medication errors
- **CQUINs from 2012-13** - providers are expected to ensure that all the CQUIN's from 2012-13 are mainstreamed into core delivery:

  - VTE assessment on admission and appropriate chemical prophylaxis
  - Improvement in measurement of patient experience
  - Patient revolution – performance improvement
  - Dementia screening, dementia risk assessment and referral for specialist diagnosis
  - Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE
  - Psychiatric liaison
  - Improve the patient clinical pathways to reduce and redesign outpatient activity
  - Implementing changes to care from mortality reviews
  - Improving primary and secondary care communication and integrated working across primary and secondary care
  - Further implementation of ambulatory care pathways
- **Patient experience -** Providers are expected to develop an agreed work plan to improving patient experience through learning and listening to patients and their carers
- **NHS Constitution -** Providers are expected to provide services in line with the NHS Constitution
- **Outcomes framework –** WNCCG intends on ensuring that patients/clients have a positive outcome in relation to their care as outlined in the NHS Outcomes Framework:
  - 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
  - The CCG will ensure that all providers adopt the NHS Outcomes Framework along with corresponding outcomes indicators.

Sustainable Specialties and the frail elderly

- **Sustainable specialties and frail older people's workstream** - All providers are expected to work collaboratively across the Arden System to implement agreed service reconfigurations identified through the Sustainable Specialties and frail older people's workstream
- **Frail elderly** - Providers are expected to implement the recommendations of the NCEPOD reports, particularly the outcomes of 2010 report 'An Old Age'
- **Regional milestones**
  - Enhanced recovery to be implemented for the four nationally identified specialties
  - All acute trusts with an obstetric unit to have a midwifery led birthing unit in place

Long Term Conditions, Rehabilitation and Ambulatory Care

- **Long Term Conditions**
  - Providers are expected to implement the recommendations of the West Midlands Quality Advisory Service's review of Long Term Conditions where this is achievable within existing resource.
  - WNCCG would like to work together with partners to review and implement the long term conditions pathways across the area to ensure the provision of coordinated, integrated care across hospital, community, primary care and social services
- **Ambulatory care –** WNCCG would like to commission new pathways for ambulatory patients requiring urgent assessment or treatment and expand the number of conditions which are managed under an ambulatory pathway in order to avoid admissions.
- **Rehabilitation** - Review of current pathways and exploration of whether efficiencies could be secured through a more integrated approach and more extensive community-based support
- **Discharge to assess** - Commissioners wish to explore means of enhancing integrated working across providers to implement the discharge to assess philosophy
- **Digital by default** - In line with national priorities identified within the Innovation Health and Wealth report, achieve a demonstrable shift in the use of non face to face consultations and links to Telehealth as an alternative to hospital attendance.
- **Navigating the system** – Commissioners require the Trust to make a shift in clinical practice to sustainably re-achieve the levels of discharge of patients to community team/intermediate care support attained in the "5-a-day" project and look at expanding this further. Non-recurrent funding has been provided, in 2012-13, by WNCCG to the Trust to support the achievement of this shift.

Care Homes and End of Life Care

- **End of Life Care** - Commissioners wish to explore means of enhancing integrated working across providers to support individuals at the end of life. Agreeing with the provider an action plan to ensure a system wide approach and ensure the implementation of the national programme for "Transforming End of Life Care in an Acute Setting" to identify, manage and discharge in the most appropriate way in the best interests of the patient.
- **Care Homes**
  - Developing support services that can work with homes (involving GP and specialist input) to care for patients proactively as to avoid instability but also to respond rapidly to assess and advise patients with deteriorating health
  - Ensure residential staff have sufficient training and support to enable residents to die in the home rather than in hospital
  - Standardisation of care across nursing homes to improve level of care across WNCCG and reduce unnecessary attendances to hospital

Stroke and Cancer

- **Stroke**
  - Providers are expected to implement the recommendations of the SHA-led review of Stroke Services where this is achievable within existing resource
  - Work jointly with WNCCG to review the stroke rehabilitation pathway and implement the new model of care
- **Cancer**
  - Providers are expected to raise local awareness and early diagnosis for agreed cancer initiatives
  - Providers need to adjust assumptions for the change in Chemotherapy tariff; impact of chemotherapy drugs and specialised commissioning; impact of sub-cut chemotherapy and provision of care
  - Providers should work with other agencies to signpost to Citizens Advice Bureau/financial support
  - Providers need to adjust capacity assumptions for endoscopic capacity/introduction of flexi-sig within bowel screening
  - Providers need to increase the percentage of Image Guided Radio Therapy (IGRT)/ Specialised commissioning
  - Providers may need to develop plans to test HPV for head and neck cancer
  - Providers need to adjust assumptions for the impact of reduced availability of BCG to treat bladder cancer, leading to higher numbers of surgery and impact on critical care
  - Providers to ensure PET scanning to assess response to cancer treatment is in line with evidence based practice
  - GEH needs to increase MRI capacity
  - Providers need to conform with the Cancer Outcomes and Services Dataset
  - Providers need to ensure complete cancer staging information is sent to WMCIU for at least 70% of all cancers

Mental Health, Learning Disabilities, Substance Misuse and Dementia

- **Integrated Acute Liaison** - Acute providers are expected to ensure that staff are appropriately trained to respond in an appropriate and sensitive way to people with suspected mental health needs and be able to make appropriate referrals to the Integrated Acute (psychiatric) Liaison services. The expectation is that key metrics will be included within the contract in order to support delivery of the service and to expand the service in order to ensure patients on wards are reviewed in a timely manner.
- **No health without mental health** - As employers, providers are expected to implement NICE guidance on promoting mental wellbeing through productive and healthy working conditions
- **Alcohol related admissions** - Commissioners wish to explore means of extending multi-agency strategies and pathways to reduce the number of alcohol related admissions

- **Dementia** – Patients with dementia are identified within the trust early and the appropriate referral for early intervention and support is made to slow the rate of memory loss and hence the period of time for which intensive, often residential, support is required
- **Learning Disabilities** - Reasonable adjustments are in place to accommodate the health needs of people with learning disabilities accessing acute care. Building on the evidence from national review and direction about the particular health risks and issues impacting on people's experience and outcomes of health services.

Childrens' and Maternity Services

- **Transition from Children's to Adult services** - Commissioners wish to explore means of enhancing integrated working across Providers to support young people in the Transition to adult services
- **Paediatrics** - Support the transfer of paediatric inpatient services to UHCW, with all other services remaining at GEH alongside a newly established 16-hour short stay paediatric assessment unit (SSPAU).
- **Maternity** – see a reduction in C-Section rates and an improvement IUGR inter Uterine growth restriction screening detection to reduce the number of still birth babies in line with the national average

Emergency care

- **Emergency and urgent care redesign** - The CCG intends to work with stakeholders to commission a redesigned emergency and urgent care system. The aim being to ensure that patient's needs are being met in an emergency through integrated service provision for urgent primary care, minor illnesses/injuries and 999 emergencies.

Outpatients and Elective Care

- **Outpatient pathway redesign** - Commissioners wish to streamline outpatient pathways to improve patient experience, remove unwarranted attendances at hospital and reduce resource burden to both commissioners and providers
- **Consultant to Consultant referrals** – commissioners wish to minimise consultant to consultant referrals and will not pay for consultant to consultant referrals outside of the policy
- **Physiotherapy** - Commissioners will explore means of increasing the cost effectiveness of physiotherapy services improving integration across the primary and secondary care interface and by agreeing criteria to ensure that patients both access the service appropriately and are discharged in a timely manner when treatment is not having the desired clinical impact
- **Access** – all services commissioned should be in line with national targets for patient access in line with the NHS Constitution
- **Pathways** – commissioners wish to agree a programme of pathway reviews to ensure that they are efficient, person centred and effective.

Capacity and demand plan

- **Bed base** – commissioners wish to agree a plan with the Trust that will adjust its bed base to reflect the impact of service change and reductions in length of stay, for example; the shift from inpatient management to day case and Outpatient Procedures; the impact of schemes to expedite discharge from hospital.

Prescribing and Secondary Care Drugs

- **High Cost Secondary Care Drugs –** No payment for PBR excluded drugs unless Provider can demonstrate compliance with NICE guidance or agreed local prescribing protocol
- **Home care medicines** - Providers are expected to have agreed a 3 year strategy for home care medicines and services and their supply, as per the DH Homecare review, and to be implementing year 1 of this from 1 April 2013.
- **Blueteq** – Agree a rollout plan to implement Blueteq proformas across the Trust to ensure high cost drugs are being used in line with NICE/local criteria.
- **Preferred products** – to review the use of less expensive products, (e.g. biosimilars, Certolizumab) with clinical engagement to generate cost efficiencies for both provider and commissioner.
- **Repatriation** – to explore the opportunities for repatriation of drugs which can be purchased cheaper by the hospital than by community services or homecare companies.

Tuberculosis (TB) Service

WNCCG along with the other Arden CCG's intends to review the current TB service to ensure that the best outcomes are achieved for patients within the current resource

Patient Transport Services

Commissioners intend to retender the service; this will impact on the 2013/14 contract

General

- Commissioners expect that all providers will comply with all guidance issued by the Department of Health in relation to new or revised targets, counting and charging, changes to PBR and other national priorities
- Commissioners expect that all providers will have plans in place and be able to demonstrate compliance with/progress towards (as applicable) the national innovation targets as set out in Innovation, Health and Wealth (November 2011)
- The Trust is expected to achieve national requirements in respect of the national Maternity Pathway tariff
- Non-PBR prices – the national tariff inflator/deflator figure per the 2013/14 Operating Framework will be applied to all non-PBR prices
- Local prices will be agreed and offer flexibility to support innovation in care pathway redesign

Terms and Conditions

- All providers will be expected to provide CCG specific contract monitoring reports as from 1 April 2013
- Commissioners will not pay for any self-referrals to outpatients unless as part of an agreed pathway
- Commissioners will not pay for any cancelled operation on the day of the operation for non-clinical reasons
- No payment for consultant to consultant referrals outside policy
- No payment for LPP/Aesthetic procedures outside of policy
- No payment for PBR excluded drugs unless Provider can demonstrate compliance with NICE guidance or agreed local prescribing protocol
- Where an incomplete data set is submitted, 5% of the funding will be withheld until the full data set is submitted on which Commissioners will then raise queries, as appropriate
- Target response times to be agreed for Advice and Guidance requests made via Choose and Book
- All providers are expected to share via the CQR meetings, the quality impact assessments that they undertake for their internal cost improvement programmes
- All providers are expected to share via the CQR meetings, any reports they prepare for their own Boards in relation to Energising for Excellence
- Electronic transfer of letters needs to be universal
- Discharge letters to include clear description of recommended follow-up regime/discharge care arrangements
- Any proposed changes to PBR prices must be notified to the CCG by 1 January 2013. Changes to non-PBR prices will only be agreed if it is shown that existing prices are clearly out of line with national benchmarked figures
- Provider to notify commissioners of proposed pricing structure changes associated with those areas that will attract a local tariff e.g. Excluded Devices. Commissioners intend to review non-PBR pricing structure to ensure this is in line with West Midlands providers
- Provider to notify commissioners of its intentions to charge for new activity or make changes to existing pathways that will impact on costs e.g. QIPP

7.6 Specific Commissioning Intentions: South Warwickshire Foundation Trust Community Health Services

We, along with other CCGs in the area, would like to work with South Warwickshire CCG to secure the following community commissioning intentions for 2013/14 in the SWFT contract on our behalf:

- Ensure care is based on need
- Prevent inappropriate secondary care admission
- Facilitate early secondary care discharge

- Prevent inappropriate admissions to nursing and residential care so that patients do not become unnecessarily institutionalised and are given every opportunity to regain their independence and return to their original place of residence
- Reduce impairments attributable to long term conditions
- Rehabilitate to the optimum so that patients return to the level of independence they had before becoming unwell
- Promote social inclusion where appropriate
- Allow the development of patient capability in self directing their care and self managing their conditions
- Support integrated health and social care for children and young people so that the transition between care provided for a child as he or she grows up is managed
- Allow patients to end their lives in the place of their choice
- Adopt the principle of "referrer decides" so that patients who are referred to community health services are accepted, trusting the judgement of the referring professional

Specifically for Warwickshire North CCG we would like to ensure the following is commissioned:

- **Intermediate care services** - Issues have been flagged by GPs with regard to gaining access to Intermediate Care Services for GP referred patients. WNCCG would wish to see in place mechanisms through which access to and responsiveness of the locality team services can be monitored.
- **Community integrated team**
    - Within the development of the community integrated team model, WNCCG would wish to see the team demonstrate it's contribution to supporting patients with low level mental health needs and, hence, an explicit connection to the IAL service in development.
    - Aligned to the WN CCG work with the George Eliot Hospital to improve patient flow, the CCG would wish to continue the current collaborative working with SWFT community services to ensure that the link from hospital to the integrated community teams is embedded within the GEH processes.
    - The CCG would like to explore a single point of access into community services
- **Care Homes** - WNCCG is cognisant of issues with regard to the capability and resilience of the care home sector. The CCG would wish to work with the community teams to ensure that community services as they develop continue to enhance the wider system capability, preventing crisis intervention and working to reduce unnecessary admissions to hospital.
- **Tissue Viability** - WNCCG is aware of the pilot work on reshaping leg ulcer management to include specialist tissue viability input to clinics and the successful impact that this had on healing rates and therefore outcomes for patients. The CCG supports proposals to roll out this model within the current resource and the savings both in prescribing and District Nursing time that this will deliver.
- **End of life Care** - Within North Warwickshire a pathway to support the fast track discharge of end of life patients has been developed with the George Eliot Hospital Trust. The pathway is

set for testing during 12/13 and the WN CCG would wish to see this pathway embedded in practice.

7.7 Specific Commissioning Intentions – CWPT

We recognise that significant work in shaping longer term vision has been carried out, and our commissioning intentions reflect on this work to date. Our commissioning intentions therefore focus on:

- Ensuring that there is always appropriate rapid access to mental health services by patients who need it
- Making Every Contact Counts to be implemented to provide equal access for this group of patients to health promotion, screening and vaccination in order to improve the physical health of mental health and learning disability patients ;
- Continuation of a commitment to the repatriation and out of area work stream, seeking to bring people back into local services and to reshape services to accommodate such individuals and to prevent people going out;
- Continued redesign of the eating disorder services to ensure there is a consistent and comprehensive pathway across the local health economy in Coventry and Warwickshire;
- Continued progression of the redesign of older people's services to roll out a community based intensive treatment service; reduce the bed base but recognising the need to respond to an increasing elderly population.
- Ensure the memory assessment services offers timely diagnosis and signposting;
- The Roll out of a Single Point of Entry which supports primary care clinicians in managing users where appropriate;
- Reviewing, developing and rolling out thresholds across primary and secondary care services;
- Moving towards integration and/or alignment with community nursing services to ensure seamless case management and appropriate interventions;
- Reiteration of the menu of options to support public mental health services in order to ensure effective support is available for people to self manage low level mental health issues; and
- Review of mental health liaison services in partnership with GEH recognising a joint responsibility to understand the issues and problem solve accordingly
- Review of the current access and effectiveness of IAPT services

7.8 Specific Commissioning Intentions - CAMHS

In partnership with the lead commissioner for children's services we have developed the following commissioning intentions for CAHMS services:

- Improving information and support about maintaining mental health including reducing stigma through the provision of leaflets and web based resources in partnership with Public Health;

- Explore the options to extend targeted low level counselling and CBT therapy for depression & anxiety in line with the children's IAPT work;
- Reduction in CAMHS waiting times to adhere to national standards;
- Improving the transition into Adult mental health services;
- Improving the outcome monitoring to measure effectiveness of interventions;
- Monitor admissions with Specialist Commissioners & explore the options for the development of a tier 3.5 intensive home support service;
- Continuing to develop clear and transparent clinical pathways including thresholds for agreed conditions across specialist CAMHS, Primary & community care services.

7.9 Pathology Contract

The Commissioners are keen to work with the Pathology Network in order to achieve the following for the Contract 2013/14:

- To continue the implementation of Order Comms to a successful completion.
- To work with the CCG to continue the review of Phlebotomy services to improve both Domiciliary and clinical setting phlebotomy services to the advantage of patients and to improve equity of access for patients.
- To review and continue ongoing CQUIN projects where necessary
- To work towards "Transforming Pathology Services" goals to ensure the effective continued Pathology Services for patients in the Coventry and Warwick areas.
- To deliver a financial reduction across the cluster for 13/14.

7.10 Ambulance Service

The Commissioners are keen to work with the West Midlands Ambulance Service in order to achieve the following for the Contract 2013/14:

- To continue to improve call triage and clinical treatment advice to ensure the correct response for patients. To improve "hear and treat".
- To work with trusts to resolve where possible delays in turnaround times, to follow up and seek advice from other Trusts on their reduction and resolution in delays.
- Reduce conveyance to Emergency Departments unless clinically necessary. To seek other services input that would be more appropriate for the patient.
- To promote the 111 service where appropriate.

7.11 NHS 111

All health economies are required to provide an NHS 111 service by April 2013 and work is already underway to implement this. In 2013-14 the CCG will work in partnership to implement this as per national direction and policy. The aim of the service is to ensure that people who have an urgent health need are directed to the most appropriate service. NHS 111 will receive, and triage calls before signposting to and booking patients into the most appropriate care services. The CCG will continue to support the programme of work currently being undertaken by the Department of Health. It is expected that NHS 111 will replace the Warwickshire Helpline service.

7.12 Information Management & Technology

Appendix 1 details the IM&T commissioning intentions for 2013-14.

8 Timetable

The following details the timetable for an agreed contract by no later than 31 March 2013 (or earlier if instructed to do so):

Date	Action
September 12	Commissioning Strategy and Intentions Workshops
30 September 12	Commissioning Intentions sent to providers Counting and charging letter received from providers
October 12	1st draft of WNCCG medium term financial plan to confirm the likely QIPP gap Governance arrangements to oversee planning process in place (e.g. QIPP & CQUIN Technical Groups) Further consultation with Member Practices and wider stakeholders re: draft Commissioning Priorities
October - December 12	Contract Negotiation Principles Workshop – CCG and Provider Develop financial and activity modelling outputs to support individual CCG baselines per contract Develop QIPP proposals including financial and activity modelling Develop CQUIN schemes Contract negotiation meetings
1 November 12	Draft of 13/14 Commissioning Plan submitted as part of CCG Authorisation evidence
Mid December 12	Publication of National Operational Framework (tbc) plus publication of national tariff and refresh of headline and supporting indicators
End December 12	Confirm individual CCG baselines
End December 12	QIPP plans signed off with leads identified Confirm individual CCG baselines CQUIN agreed Activity and financial modelling
11 January 13	Formal Contract offer issued to Provider
17 January 13	Contract agreed – full contract agreed as requested by George Eliot Hospital.
January – March 13	QIPP implementation phase
28 February 13	Activity & Finance and principal Terms &Conditions to be agreed and confirmed to SHA (will be agreed as part of contract sign off in January)
March 13	Executive to Executive escalation meetings (if required)
31 March 13	All contracts to be signed (in line with contract agreement in January)

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Appendix 1

ARDEN COMMISSIONING SUPPORT SERVICE

COMMISSIONING INTENTIONS for 2013-14 – Information Management and Technology

The funding route for IM&T developments post March 2013 is somewhat unclear. Similarly, until their 2013/14 allocations are announced later in the year, CCGs are not in apposition to make any firm commitments as to their level of IM&T investment (if indeed funding is via CCG budgets). Any new IM&T developments will need to be prioritised along with all other service developments and cost pressures. Within that context, Arden CCGs remain committed to utilising IM&T technologies to promote safe, effective, quality patient care by facilitating information sharing and communication across service providers, supporting alternative home-based care pathways and promoting efficient operating processes. We would look to all NHS providers within the local health system to work collaboratively to maximise the benefit secured from both existing and any new IMT investment.

We would expect Providers to work jointly and with CCGs to:

- Implement and maximise benefits from the current C&W Collaborative IM&T Plan and any subsequent agreed iterations, including
- Complete and fully exploit current collaborative schemes including:
    - E-communications between Secondary Care providers and GPs
    - Telehealth pilot projects involving SWFT, UHCW
    - Warwickshire Common Assessment Framework Demonstrator
    - Point-of-care information sharing pilots, similar to the Cumbria model, about to be taken forward and later developed into a full scale solution if pilots prove realisation of expected benefits. This includes but is not limited to a requirement for shared Primary and Community Care records.
    - COPD pilots - encompassing information sharing and the use of patient self- care tools. Need to ensure benefits & lessons learned are identified and disseminated.
    - Summary Care Record completion of rollout to EMISWeb practices and further exploitation of benefits within out-of-hours services, emergency care departments, hospital pharmacies and other settings as benefits warrant and in accordance with national strategy.
    - Use of Extranets to support cross sector communication and pathways
    - Implementation of Electronic Prescription Services Release2 to complete the national initiative towards a paperless system.
    - Make steady progress towards the national target to give patients secure on-line access to their personal GP records by 2015

- EOL / palliative care – obtain full benefits from EOL electric coordination system due to be implemented by March 2013
- Electronic support for other pathways including frail elderly and ambulatory care as service requirements become more clearly defined and understood

- Complete trials, business cases and seek to agree jointly funded implementations including:
  - GP e-requesting – currently a full business case is being written with the expectation of go/no-go decision in October and then rapidly moving through procurement and delivery phases if approved
  - Shared business intelligence / analytics across commissioners and providers where practical
  - Patient / citizen health portal – slated for further consideration by Commissioner/Providers jointly during the latter half of 2012/13
  - Robust and standardised operational and clinical systems across providers consistent with patient safety requirements – current projects include LIMS/RIS/PACS replacement projects
  - Continue to take steps to understanding what the Lorenzo Programme still might have to offer the Local Health Community. Lorenzo e-prescribing is one of the areas UHCW is interested in
  - Take a single / consistent approach to messaging, infrastructure and support services. This includes shared infrastructure projects currently being discussed and agreed by IT Leads, resulting from the work undertaken by the Joint IT Infrastructure post holder now appointed to work across the provider / commissioner community
- Jointly examine the 'Power of Information' Strategy document, and bring forward further plans for better connected information and IT systems aimed at providing improved access to linked records for both clinicians and patients.

  For example, enabling service users to access their primary and secondary care records, be given the facility to enter information into their care records, provide feedback on treatment progress, and update their demographic information.

  Consider the national initiatives and good practice published following and in the context of the Strategy paper including 'Digital by Default' and the QIPP papers now referred to below.

- 'Digital by Default':

  Work jointly with CCGs to examine progress being made (and the potential to progress further) towards digitally enabled healthcare processes as identified by the Digital by Default paper recently published by Department of Health, Innovation and Service Improvement Directorate. Digital by Default is aimed at providing capability for the general public to manage their healthcare digitally wherever possible. It has a close fit with the ambitions articulated in the 'Power of Information'.

  The 10 healthcare processes identified in the report (along with claimed associated savings) are as follows:

  - minor ailments and LTCs on-line assessment (interactive triage with video consultation)

- online booking of Primary Care appointments
- remote primary care pre-assessment (triaging of GP appointments)
- digital appointment reminders
- mobile-enabled community nursing
- on-line or kiosk Secondary-Care anaesthetic pre-operative assessments (with telephone consultation where necessary)
- remote post-surgical follow-ups (telephone/Skype) following discharge from Secondary Care
- remote follow-ups non-surgical following discharge from Secondary Care,
- remote communication (SMS/email) of negative test results
- electronic delivery of Secondary Care patient letters (to patients as well as GPs)

QIPP Digital Technology:

- In context of the above, to consider some of the specific technologies referred to in the recently published DOH QIPP Digital Technology Essentials Guidelines, i.e. to consider what is currently being achieved and how best to obtain additional benefits from the digital technologies identified:
  - Digital dictation
  - digital pens
  - mobile working
  - AIDC/RFID
  - telecare
  - telehealth
  - telemedicine
  - SMS
  - digital clinical correspondence
  - VOIP
  - video conferencing
  - virtualisation
  - managed printing

- Ensure that collaborative and provider-specific IM&T requirement of new agreed care models and pathways, including the application of thresholds, are determined and solutions implemented.
- Support the development of more timely data flows between providers and commissioners and improve data quality
- Develop data and reporting mechanisms to provide visibility of Mental Health, Community and Continuing Healthcare expenditure at practice and consortia level

- Use digital technologies effectively to improve the efficiency, quality and safety of provider services
- Work with the CSS and CCGs to minimize any IM&T related issues resulting from the closure of Cluster PCTs and the handover of responsibilities to new accountable bodies.