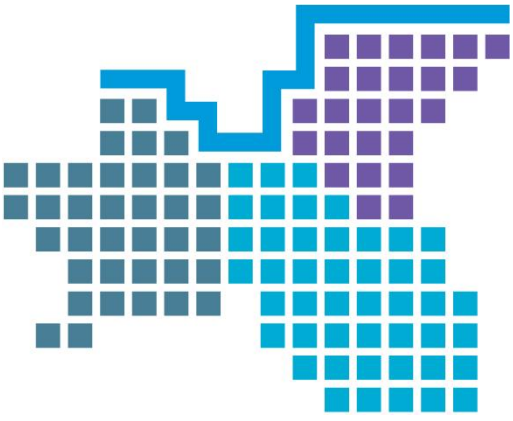
NHS
Wandsworth
Clinical Commissioning Group

Wandsworth CCG
Commissioning Intentions - 2015-2016 refresh



Foreword

Last year we produced our two year Commissioning Intentions, developed with the engagement of our patients, GP membership, Localities and Clinical Reference Groups, which demonstrated the depth and breadth of our work across clinical specialties, and with other health and social care partners, and showed how we intend to make best use of our available resources to ensure that we deliver improved outcomes and improvements in the health and wellbeing of the population of Wandsworth.

This document, which is a refresh of the 2014-2016 Commissioning Intentions, has been developed to specify the local focus for Wandsworth CCG, reflecting key elements of the refreshed Wandsworth Joint Strategic Needs Assessment, the Health & Wellbeing Strategy and the increased emphasis on integration of health and social care commissioning, whilst acknowledging the South West London wide Commissioning Intentions.

The document sets out:

- The background and context within which the refresh has been developed.
- Clinical leadership & the role of the Localities and Clinical reference Groups
- A summary of the 2014-2016 Commissioning Intentions
- Progress to date against the 2014-2016 Commissioning Intentions
- Revisions/additions to the 2014-2016 Commissioning Intentions

Our work continues to be underpinned by our vision encapsulated in the phrase ***"better care and a healthier future for Wandsworth"*** and the principles outlined below.

- Patient focused
- Outcomes driven
- Principled
- Collaborative
- Progressive & Professional

Our focus this year will be to continue to innovate and transform service delivery based around the needs of our patients, delivering high quality care in community settings – bringing care closer to home. We will continue to prioritise the reduction of health inequalities and improving services and outcomes for our most vulnerable patients. This will be underpinned by a robust and effective patient and public engagement programme, placing our patients at the centre of everything we do. We will work with partners to ensure we secure quality and value for money from existing services, addressing this through service improvement or decommissioning as appropriate and will continue work to begin to commission services on an outcomes based model.

Signed

Nicola Jones (Chair)

Graham Mackenzie (Chief Officer)

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1. Background and Context

Wandsworth CCG have made significant progress towards achieving our vision and we are now beginning to accelerate the transformation of service delivery and systematically improve the standards of care and outcomes for our patients. The purpose of these commissioning intentions is to provide an indication to current and potential providers of how, working with our partners, we intend to shape the delivery of health services for the population of Wandsworth. It is not intended to set out all of the activities that we will be undertaking in this year but will;

- Provide the context for commissioning changes
- List agreed commissioning intentions including changes that will improve the quality of services and/or achieve improved value for money
- Signal to providers the areas where resources may be reducing or where new services may be required.

1.1 South West London Collaborative Commissioning Intentions

We know that some of the challenges that our local NHS faces are not unique to Wandsworth CCG and therefore we are working in partnership with CCGs across South West London to address common issues. We know there are underlying challenges in our health economy that must be addressed to successfully build a sustainable care model. These include;

- Managing increased demand for services from our frail elderly population
- Delivering robust and effective community services, bringing care closer to home
- Working together to develop a configuration of acute services which, with an overall reduced 'footprint' ensures sustainability and affordability.

This work is reflected in the South West London Commissioning Intentions of which we are a key participant and signatory. We have therefore been cognisant of this work in the development of our local Wandsworth CCG Commissioning Intentions.

1.2 Integration

Everyone Counts published by NHS England in December 2013 established an expectation for local health and care economies to work together in partnership in order to achieve the transformational change required to address the challenges facing the NHS. This was supported with the simultaneous launch of the Better Care Fund by NHS England and the Local Government Association promoting closer collaboration between health and social care.

We know that the integration of services will ultimately determine the future model of care for our population and from our engagement work we know this is supported by our service users. We welcome the opportunity to work in partnership with our Local Authority, service providers and neighbouring CCGs to determine how we will respond to the complex and interrelated challenges facing us; improving outcomes; securing financial sustainability; and ensuring a safe transition to new models of care.

1.3 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) is 'a systematic method of reviewing the health and wellbeing of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities'. A detailed JSNA was prepared and finalised in 2011 and this was refreshed in 2014. The key messages detailed below include the recurrent issues from the 2011 JSNA, and any additional areas of need with poor performance or a worsening trend. In addition two further tables demonstrate issues for smaller cohorts of patients with intensive needs, and specific areas of inequality. The key messages are summarised as:

- Mental health; the number of people that may have a mental health disorder (48,500), the cost associated with care (£53m for Wandsworth), and the impact on other conditions or areas of life particularly for black ethnic groups make this a significant issue.
- Childhood immunisations and breastfeeding; MMR at 2 years was 83% against a target of 95%, and breastfeeding at 8 weeks was 73% against a target of 76%. Additionally breastfeeding uptake is lower in more deprived areas.
- Domestic violence; 21% annual increase in reported domestic violence offences
- Care of vulnerable families. Issues include availability of family housing, long term unemployment, domestic violence, and poor maternal mental health or access to services. Particular issues for children also include gang involvement, sexual exploitation, female genital mutilation, childhood accidents and support for children with caring responsibilities, or children with disabilities.
- Care of the elderly; relatively poor rates of excess winter deaths (at 25.3 for 2009-2012and falls injuries with 727 injuries in 2011/12.
- Lifestyle; Sexually Transmitted Infections are particularly high; alcohol related hospital admissions have increased year on year. The prevalence of smoking, being overweight and lack of physical activity is relatively good in Wandsworth, but at 16%, 50% and 23% respectively, but there is still an issue with geographical inequalities.

Intensive Needs

- Learning disabilities; An acknowledged low number of people known to services, 1,342 representing 23% of the anticipated population.
- Children looked after; This cohort consists of 210 vulnerable children with poor life chances, and particularly for the care leaver group of approximately 20 a year.
- Tuberculosis; New cases of TB have remained stable but only 79% completed treatment in 2012, below the 85% target.
- Care Home Residents; To ensure the provision of appropriate and equitable services to the estimated 800 care home residents in Wandsworth.
- Offender health; 1000 people on the probation caseload, with direct health impacts for the offender, and indirect impacts on the offender's family and friends.

Inequalities

- Excess mortality for residents in more deprived communities under the age of 75; The most common causes are cancer and cardiovascular disease, however people will typically have multiple long term conditions including complications arising from diabetes, and respiratory diseases.
- Lower educational attainment and lower Personal Social and Emotional attainment in Reception year. More deprived and some ethnic communities have lower levels of attainment with associated long term issues.

- Long Term Unemployed; With an emphasis on building skills to find work, and linking opportunities to the regeneration plans in Wandsworth.
- Air quality; Ongoing need to monitor air quality in congestion areas
- Access to open spaces; To promote the use of open spaces particularly where access is limited.

The full Joint Strategic Needs Assessment document can be found at http://www.wandsworth.gov.uk/jsna

1.4 Key Service Standards

NHS England has selected to focus on 8 key service standards of CCG performance. These are:

1. Urgent and emergency care (A&E)
2. Referral to treatment within 18 weeks
3. Cancer access
4. Improving access to psychological therapies (IAPT) & Recovery Rates
5. Dementia diagnosis rates
6. Patients waiting over 52 weeks
7. Category A Ambulance Calls
8. C. Difficile Infections

These Commissioning Intentions have therefore been developed to ensure optimal performance in these 8 key service areas.

1.5 Health inequalities

The gap in life expectancy between the most and least deprived areas in Wandsworth widened between 2001-05 and 2006-10. Wandsworth now has one of the widest gaps in London, for both men and women.

There are approximately 2,800 deaths in Wandsworth a year and approximately 1,000 of these are of people under the age of 75. The two most frequent underlying causes of death in the under 75's are cancer and circulatory disease with approximately 220 and 150 deaths respectively.

The most significant impact on health inequalities are likely to be from local improvements to community and home-based services.

1.6 Health & Wellbeing Strategy

The Wandsworth Joint Health and Wellbeing Strategy is prepared by the Wandsworth Health and Wellbeing Board; the primary purpose of the Health and Wellbeing Strategy is to add value to the priorities arising from the JSNA. The Joint Health and Wellbeing Board have identified three areas of focus that will help drive improvements in outcomes for patients.

The Wandsworth Health and Wellbeing Strategy has three priorities **– resilience, prevention and integration.**

1.7 Ensuring Quality

Another core element of the strategic background within which the CCG commissions services is the overt focus on the quality of care that patients receive. This includes the requirement that robust assurance systems that are in place so that the public can have

confidence that high quality standards are set across all health and social care services, and regularly monitored to ensure adherence to those high quality standards.

The CCG's first priority is to commission services that offer quality for local people. At its simplest, "quality" is defined as care that is safe, effective and provides as positive an experience as possible. This definition of quality sets out three dimensions:

> **Patient Safety -** Commissioning high quality care which is safe prevents all avoidable harm and risks to the individual's safety; and having systems in place to protect patients.
>
> **Clinical Effectiveness -** Commissioning high quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes. Making sure care and treatments achieve their intended outcome.
>
> **Patient Experience -** Commissioning high quality care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what the individual wants or needs, and with compassion, dignity and respect. It's about listening to the patient's own perception of their care.

The CCG will continue to strive to secure positive health outcomes for local people and continuously improve the quality of services. The CCG recognises that securing and improving quality cannot be achieved by the CCG in isolation and that patient' journeys cut across primary, secondary and specialist care, health and social care, with services commissioned and delivered by multiple organisations and professions both within and outside the NHS.

The CCG appreciates the commitment of partners to work collectively in improving quality and recognises that systematically and continuously improving the quality of services across settings of care represents a significant challenge for the CCG and partner agencies. We will continue to support and collaborate with provider organisations to improve the quality of services provided, whilst holding them to account for standards of service delivery.

1.8 Primary Care

There is substantial evidence that integrated care, incorporating primary care based risk profiling and care planning, has positive benefits on the health and social care system. Much of this evidence demonstrates that patients with multiple LTCs (often those who use the greatest amount of health and social care resource), benefit significantly from a joint care planning approach and from having a named GP or nurse at their local surgery whose focus is on keeping them well. Over the next 5 years, Wandsworth CCG will continue to implement and evaluate this model of care, which has demonstrated significant improvements and efficiencies elsewhere in the UK. Case studies of the general practice care planning model from Cumbria and North West London (Reeve (2013) and The King's Fund (2013)) show that in order to successfully implement this model and address the myriad of other challenges facing general practice, it must be rolled out in combination with a series of other primary care initiatives.

Firstly, general practices must be given the opportunity to change the way they work – reducing waste and inefficiency. They need to be given the space to reflect on what needs to change and given support from expert change agents working within the practices. Wandsworth CCG have already begun this process through investing in the Members Development Programme and Productive General Practice in 2013/14, however, to ensure that the improvements in practice are embedded and that changes made are sustainable, it is vital that this investment is maintained.

Secondly, an ongoing programme of workforce development is essential to ensure that staff have the right skills to deal with more complex patients effectively. The staffing model must be effective, meaning that the skills of practice nurses, HCAs etc. are fully utilised and that issues such as fluctuations in the workforce, use of locums etc. are recognised and addressed.

Finally, broader issues related to the configuration of general practice must be taken into account. Historically enhanced services such as diagnostic tests have been commissioned from individual practices. Whilst this has been successful in increasing the range of services available to patients locally, it has also generated inequality, as smaller surgeries have struggled to deliver these enhanced services for their patients. It is therefore intended that over the next 5 years, Wandsworth CCG will begin to contract enhanced services through a single GP Federation (of which all practices in the Borough will be members) and in this way the CCG can ensure they are commissioning an equal level of service across the Borough

1.9 Children's and Adults Safeguarding

The CCG is accountable for safeguarding adults and children within the economy of Wandsworth. This includes both NHS and non NHS funded care. In relation to children's safeguarding a key priority for the CCG is to work with the Local Authority as the Corporate Parent to ensure those children deemed as looked after are healthy and supported throughout their early years which includes the transition from child to adulthood. In relation to adult safeguarding a key priority for the CCG will be to continue work with public health and clinicians across the economy to ensure that those most vulnerable and socially isolated are free from harm

1.10 Engagement - Empowering the Patient and Public Voice

The CCG has a strong record in engaging patients and the public in the development of services. We are working to ensure that the patient voice is embedded throughout the commissioning cycle, from patient representation at our Clinical Reference Groups, Engagement events throughout the Borough and user engagement in the redesign of services. This work, which is led by the Chair of the Patient & Public Involvement (PPI) Reference Group, is part of a longer term process to ensure effective engagement throughout the commissioning cycle and the information we are gathering is being used to further inform future engagement, recognising that patients, carers and service users have valuable expertise and insight which will be used to inform service redesign and commissioning decisions.

Clinical Leadership

2.1 Locality Groups

Wandsworth CCG is formed from three localities each with separate and specific population and health needs. We passionately believe in real clinical leadership in all parts of the commissioning cycle – the priority setting, the planning, contracting, performance management and review of commissioned services and under the leadership of the elected clinical lead each of the localities have come together with Public Health support to determine the key local priorities in their area.

2.2 Clinical Reference Groups (CRGs)

Wandsworth CCG has established Clinical Reference Groups covering each of the key service areas, which bring together a multi-disciplinary group of professionals and patient representatives to consider ways in which improvements to patient pathways can deliver improved outcomes and experience for patients. Each CRG, chaired by an appointed Clinical Lead, develops their annual work programme, which is been approved by the CCG Board. There are also a number of task and finish work streams, which are also clinically lead but do not fall within the work plans of individual CRGs such as the procurement of a tier 3 Bariatric Service.

CRGs are the vehicle by which clinical leadership, patient voice and integrated working come together to deliver service redesign that achieves real health improvements for patients.

CRGs report at CCG Board at least once a year to put a real clinical focus into the discussions and delivery of service improvement at Board level.

The range and composition of the CRGs evolves in accordance with the agreed priorities of the CCG and as priorities are addressed and new ones emerge the role of the CRGs will be continually redefined.

2.3 Clinical Commissioner Reference Groups and Clinical Quality Review Groups

Placing clinical leadership at the heart of the contracting process, clinical leads chair and attend monthly meetings that are dedicated to getting the best value – right care at the right time in the right way – for patients and reviewing all aspects of the quality of that care.

Clinical Commissioner Reference Groups and Clinical Quality Review Groups are in place for all services the CCG commissions – acute (hospital) care, mental health services and care provided in community settings.

3. A summary of the 2014-2016 Commissioning Intentions

3.1 West Wandsworth Locality

The West Wandsworth Locality covers the areas of Roehampton and Putney, and the nine practices that lie in these areas. The West Wandsworth priorities build on the work and priority areas identified last year, to improve the health and wellbeing of the population and also support Wandsworth wide priorities.

These priorities have been identified in consultations with West Wandsworth Management Team and Members', The Local Authority, Public Health and the locality patient group. Following discussions it was agreed to split the priorities into two sections; key priorities focusing on our four main priorities and the secondary priorities that have been carried over and will continue to be monitored and implemented. These priorities are listed below:

1. *Engagement*
The Locality will continue to support the rollout of the Members Development Programme (MDP), the Productive GP Practice (PGP) and the work of the Patient Consultative Group. The Locality will further develop and enhanced the programme of engagement with wider stakeholders and hard to reach groups.

2. Mental Health
The Locality has worked with TAMHS to extend their pilot to West Wandsworth and the service will now be incorporated in to the new CAMHS (Child and Adolescent Mental Health) service. A successful pilot has been run in West Wandsworth of the Catch 22 Drug, Alcohol and Counselling service for 11-18 year olds. This service is continuing and Catch 22 will also now be providing services across the borough. West Wandsworth continues to work to promote identification and treatment of patients with alcohol problems. This includes practices signed up to the Alcohol DES to continue with screening (7 practices currently signed up), training for and delivery of 'Identification and Brief Advice' for HCAs, Nurses and GPs and engagement with Fresh Start clinics, one of which is sited in the locality.

3. Queen Marys Hospital
The locality will be engaging with the work around QMH and contributing to the planning and development of services.

4. Sexual Health
The Locality has already worked with the service provider to produce an information leaflet for patients around Reproductive Sexual Health services. We are working with the Public Health sexual health lead to feed into the Public Health Sexual Health Strategy and to plan how this can be taken forward in the locality.

Secondary Priorities

- Healthy Schools
- CVD
- Obesity
- Smoking
- Cancer Diagnosis

3.2 Wandle Locality

Wandle is the largest of the three Wandsworth localities, with 22 member practices serving 198,288 patients (Jan 2014), predominantly inhabiting the electoral wards of Bedford, Earlsfield, Fairfield, Graveney, Nightingale, Southfields, Tooting and Wandsworth Common.

A recent public health needs analysis showed that, whilst sharing many of the same health priorities as the rest of Wandsworth, Wandle does have locality-specific issues that could be addressed. This analysis helped Wandle Locality to choose our chosen priority areas of diabetes, COPD, obesity, health of Seldom Heard Groups and reducing inappropriate A& E attendances.

3.3 Battersea Locality

Battersea locality has a growing population of over 90 000 and a diverse population. There are areas of high deprivation and the locality has a strong inner-city profile, more so than the other localities.

In 2013/14 Battersea Locality Commissioning Group (BLCG) agreed five main priority areas, to be reviewed each year, each with a number of local initiatives to deliver on ensuring a constant flow of work streams and actions for improvement of healthcare in the local area. Local Initiatives are decided in collaboration with the Battersea PCG, LCG Management Team, Wandsworth Public Health and the Wandsworth Joint Commissioning Unit. The priority areas agreed in 2013/14 for BLCG were:

- Alcohol
- Cancer Screening
- COPD and Smoking Cessation
- Obesity (in children)
- Mental Health
- Sexual health

Review of two year Commissioning Intentions:

Seldom Heard Groups

The BLCG members have continued in making wider links with seldom heard and community groups locally by each member practice arranging visits and links with these groups and organisations. This increases GP visibility, GP awareness and develops dialogue with such groups.

Practice Visits

The clinical and management leads for BLCG have begun a series of practice visits to encourage full engagement of each practice in the commissioning of services and to ensure they provide a high level of quality in the services they provide.

Nine Elms Vauxhall (NEV) Development

Nine Elms/Vauxhall development is well underway and has already seen a rise in the population of Battersea with an estimated total of over 27,000 residents due to arrive over

the next 15 years. BLCG has been closely involved in the NEV development and with Lambeth CCG, NHS England and South London Health Partners and its impact on the healthcare infrastructure.

Social Prescribing

In 2013/14, Battersea LCG began a review of how clinicians use voluntary sector services and other advisory services to support reducing the number of patients who would benefit more by enabling them to receive advice and support from non-clinical providers. The aim of this initiative was to approach the issue of how to signpost non-medical support to patients who would benefit primarily from this non-medical intervention while simplifying the process from both GP and patient perspectives. This project in conjunction with the work West Wandsworth locality have been undertaking in parallel has now been adapted to review voluntary sector organisations, support mechanisms and patient education across Wandsworth CCG.

3.4 Primary Care

As part of the CCGs five-year plan for out of hospital care for adults, the CCG recognised that the vast majority of care starts and ends with the GP. As such the 2014/15 commissioning intentions focussed on a number of initiatives, specifically around enhancing quality in primary care, developing the range of services offered by GP practices, development of the primary care workforce and encouraging collaboration between practices in order to encourage sharing of best practice and learning.

In line with the CCG's approach to care close to home, and echoing the national policies of lead clinical professionals for patients with Long Term Conditions and those over the age of 75, in 2014/15 the CCG planned to focus on the development of enhanced services offered through the hub of a GP surgery. This workstream aims to help patients and carers by providing additional preventative services locally, encompassing health, social care, and voluntary sector and wellbeing initiatives.

3.5 Community Adult Health Services Redesign (CAHS)

Background and Introduction

The overall purpose of the Wandsworth Community Adult Health Services re-design is to achieve a high quality health care service in the community setting. This will enable Wandsworth residents and other local people to recover, improve and maintain better health and wellbeing whilst, wherever possible, providing timely intervention to stem or delay ill health and general decline.

The redesign addresses the following overarching challenges:

- Improving access to community services for patients/service users and all health and social service professionals who need assistance to maintain care for people in the community.
- Developing a complete service that has the necessary resources to provide full multidisciplinary care in patient's own homes, integrated and interlinked with primary,

secondary, social & voluntary care agencies - but not entirely dependent on them to deliver the care needed.
- Enabling seamless and timely discharge from hospitals to home and interlinking between secondary, primary and community care systems.
- Enabling effective management of human and other resources within the community with reference to how to monitor and manage a mobile and independently minded workforce
- Providing a platform where secondary care specialists (such as geriatricians) can integrate with and support community services.
- Enabling ready access and integration for primary care, social services and voluntary sector with the services and skills of community services staff.

This new model is intended to subvert the traditional medical model where care is delivered by teams dedicated to a specific operational or disease pathway. It facilitates the capacity to meet a person's care needs wherever possible by any member of any team that has the capacity and capability. This will be achieved by grouping the known individual community services into 'functions of care':

The Functions of Care are as follows:

- Access and Coordination
- Rapid Response
- Facilitated and Supported Discharge
- Maximising Independence
- Complex Care Management
- Specialist Input

Aims and Objectives of the re-design

The CCG have been working closely with the current provider to implement the model over 2014/15, prior to commencing a potential procurement process in 15/16.

The CCG are expecting the functions of care to deliver to the following aims and objectives:

- To provide high quality, fully integrated, multi-professional, community-based service meeting people's urgent, intermediate and on-going health care needs.
- To reduce service fragmentation and 'hand offs' in an individuals' care pathway.
- To dissolve complicated referral pathways, difficult access criteria and single pathway approaches to care.
- To foster a "**yes service**" culture focussed on the needs of the patient/service user.
- To enable patients/service users to remain well and independent in their own home wherever possible.
- To be a single point of contact accessing all available community care services, professionals and volunteers.
- To deliver person-centred, multidisciplinary, skilled and seamless care.
- To provide pro-active and anticipatory case management.
- To provide a reactive service delivering acute interventions when necessary.
- To operate as ***one service***, from both a clinical and a patient/service user perspective.

- To be a platform providing access for all stakeholders: secondary, primary, voluntary sector care providers as well as patients/service users and their families and carer.
- To facilitate safe and rapid discharge home if an admission is ever necessary.

Commissioning intentions

The CCG will be working towards the further development of the following:

- **An Outcome-based commissioning (OBC) Framework** which will focus on commissioning services based on the Provider delivering services that focus on improving outcomes for the patient and their carers , focusing on patient centred goals and overall service improvement.

It is anticipated that the outcomes will focus on the following key areas;

- **Clinical effectiveness, service improvement, patient satisfaction and patient safety.** The CCG will work collaboratively with other provider organisations and patient representatives to review the caseload of patients who are considered the high risk group for recurrent non-elective readmissions. This patient group requires substantive multidisciplinary support to manage their long term conditions. Multi-agencies that will be involved in defining outcomes will include CAHS, LOCAL GP's and Social services. GP's will also work with CAHS to devise joint care plans to manage patients together. In addition GP's will be required through the PACT contract to attend regular MDTs with CAHS staff to discuss the goals set to determine if they are achievable to meet the desired outcome.

- **The expansion of the Rapid Response Carer's Service.** Making this referral pathway available to LAS as well as all Community service staff and local GP's – enabling home care support to be fast tracked into an individual's home within four hours to avoid an unnecessary accident and emergency attendance potentially leading to an avoidable hospital admission due to a social care breakdown.
- **Identifying opportunities for more effective Integrated working between nursing and residential homes in Wandsworth and CAHS** through the provision of two Band 7 nurses who will be responsible for identifying any training needs and areas for improvement in nursing/residential homes, as well as being the conduit between the community multidisciplinary teams, primary care and the nursing/residential homes. The intention of this project is to identify opportunities for future development to align local nursing and residential homes to their local Community CAHS team. The aim of developing these effective working relationships is to promote equitability of services for staff in homes to access on behalf of their residents this will include all specialist services from the multidisciplinary team.

- **The Frailty Pathway** – This is a pathway that has been designed by SGH (Provider) to establish a clear and consistent processes for admitting and discharging patients aged 75 years and over. The pathway will endeavour to assist the Provider to locate patients in identified wards and promote the opportunity for more in-reach work by Community services to facilitate early supported discharges. The pathway will focus on reducing length of stay.

- **Commencement of an IV pathway** - The Provider will be required to develop a clearly defined pathway for the delivery of Intravenous antibiotic therapy (IVAB) within the Community to prevent the patients having to be admitted to hospital to receive therapy.

- **End of life care** - Joined up working between community nursing and the newly commissioned end of life care hubs – It is expected that the end of life hub will become established from January 2015. The hub staff will work effectively with Community nursing to deliver high quality end of life care that endeavours at all times to care for the dying patient in their preferred choice of location.

- **CAHS/START alignment of health and Social care re-ablement services** to deliver more efficient and effective services through the avoidance of unnecessary duplication. The alignment of these two services will focus on identifying patients for discharge in hospital and setting up assessment processes expediently to offer re-ablement care packages to support patients upon discharge.

- **Scoping of bed based services for older people within the acute and Community setting including the use of beds in QMH, RGH, and SGH older people's beds.** This work will also include reviewing the resources and bed capacity in the current system and exploring more opportunities to utilise step-up and step-down beds. At the present time the beds are not utilised in the most efficient way so this scoping exercise would provide an opportunity to review how the beds could be used more effectively for older people across Wandsworth.

3.7 Cancer CRG

Cancer - Objectives for the next year and onwards are to prevent disease progression and support patients to manage care at home wherever possible:

Improving early detection

- Improving GP access to diagnostic testing for suspected cancer and ensuring direct access for specific tests, with particular focus on the Best Practice Commissioning Pathways for early detection of cancer
- Supporting improvement in uptake of and access to screening.
- Improving education for GPs on the early signs and symptoms of cancer and working with GPs in the use of Decisions Support Tools and the Practice Profiles for cancer to help recognise any inequities in performance
- Working with secondary care to streamline the referral process for suspected cancer to minimise to possibility of any delays
- To work closely with Public Health to increase awareness of the early signs and symptoms of cancer amongst the population of Wandsworth

Delivering care closer to home

- Working with secondary care providers and third sector organisations to promote care closer to home and follow up in the community when appropriate
- Plans to assess the provision of chemotherapy services with a view to deliver closer to home if appropriate

Work for patients living with and beyond cancer

- Recognising cancer as a long term condition

- Improving services for people living with and beyond cancer with particular focus on implementing the National Cancer Survivorship Initiative recommendations
- Improving communication between secondary/tertiary and primary care
- Working towards the provision of seamless care for people with cancer

3.8 111 and OOH CRG (urgent care systems)

Urgent Care and Out of Hours

Reduce short-stay admissions by:

- A review of the one-year pilot of GPs placed in the UCC on admissions prevention work. This has been extended and we now have two GPs in place with a view to considering a third where there are capacity needs.

Reduce emergency admissions in Long Term Conditions by:

- Committing to the inclusion of a specific urgent care Commissioning through Quality and Innovation incentives (CQUINs) in the Community Services contract to focus admissions prevention work.
- There is also the planning all care together (PACT LES) which is done in primary care for patients with LTCs
- Develop the Acute Visiting Rapid Response Service in the three localities.
- Reduce A&E attendances in core GP hours by devolving responsibility to the three Locality Commissioning Groups (LCGs) as they are best placed to work with the Member practices to develop creative solutions to reducing attendances based on local population factors.
- Expanding the range of alternate care pathways for London Ambulance Service which initially commenced in 2012/13.

Reduce A&E attendances outside of core hours by:

- Monitoring the new Out of Hours contract which includes the integration of community clinics at evenings and weekends to ensure that patients are directed from111 to these services where appropriate, instead of A&E.
- Developing direct booking into community service clinics by the 111 Service.

3.9 Diabetes CRG

- Reducing the gap between predicted and actual prevalence. Nationally it is estimated that type 2 prevalence should be 25% higher. The March 2013 JSNA suggests that approximately 2000 people remain undiagnosed with type 2 and that evidence shows that as many as 50% of these will already have developed complications by the time they are diagnosed

- Progression of the implementation of the tiered model of care and ensuring alignment with the redesigned Community Services model. This includes evaluation and additional community clinics. Scoping of services provided in primary care and a study of the potential impact of the repatriation of patients from tier 3.

- Nationally, the evidence shows that there is considerable variation in the quality of services and outcomes. Significant numbers of patients are not receiving optimal initial management and appropriate on-going support in primary care. In 2010, less than 55% of people with diabetes received all 9 care processes for monitoring and managing the disease; and only 20% achieved all three treatment standards set by the National Institute for Health and Clinical Excellence (NICE), with 15% or 350,000 people not being tested for the treatment standards at all.

- The Quality and Outcomes Framework (QOF) has incentivised GPs to perform an annual foot examination in people with diabetes and to classify the person's feet as low, moderate or high risk. This is underpinned by the NICE quality standard for adults with diabetes. It also recommends that people with diabetes admitted to hospital for any reason undergo a foot examination on admission. At present, more than one in fifty people with diabetes admitted to hospital develop an inpatient foot complication that may have been avoided by risk assessment and preventative care. The foot referral pathway has recently been launched and will continue to be monitored though the application of a foot assessment in secondary care also requires scrutiny.

3.10 Respiratory CRG

Respiratory Pathway:

- To increase the number of COPD patients whose care is managed through the use of assisted technology (Telehealth)
- Development of the Pulmonary Rehabilitation Service to increase the service capacity as part of the self-management pathway for COPD.
- To decrease the number of patients with undiagnosed COPD through the implementation of the COPD missing millions programme
- Continue to work with Public Health to deliver Smoking cessation priorities across Wandsworth
- To provide education opportunities and support for primary care professionals in the identification and management of COPD.
- Continued implementation of workstream to support the NICE Asthma Quality Standards
- Implementation of the Tier 3 Integrated Pathway model providing consultant led COPD clinics in the Community.
- Increase the capacity of the Community Respiratory Specialist Nursing Team to delivery an Integrated Service for the management of COPD – this is linked to the Community Adult Health Service Redesign
- To commission a range of engagement activities to ensure that local patients, carers and residents are taking part in discussions about the future development and provision of Respiratory services in Wandsworth.

3.11 Locality Stroke and Neuro Rehabilitation CRG

- Implementation of NICE Stroke Rehabilitation guidelines and commission appropriate services in Wandsworth.
- Continued implementation of a work stream to support the NICE quality standards for stroke
- Management of people who have had a stroke by identifying stroke patients on GP practice registers.

- To review the pathway and referral criteria to ensure appropriate access to inpatient rehabilitation services in Wandsworth

Primary Care engagement to enable seamless coordination of stroke services via the:

- Commissioning of the Stroke Information, Advice and Support Service
- Commissioning of the six month review service for stroke

Support initiatives that foster active citizenship including self-management programmes

3.12 Dementia CRG

- Delivery of public health initiatives in response to the dementia needs assessment and achievement of the Health & Wellbeing strategy outcomes
- Rollout delivery of Behaviour and Communication Support service to all Borough care homes and evaluate against service outcomes (dependent funding via OBC approval)
- Mapping as-is dementia training and needs across Wandsworth health and social care system and voluntary sector in 14-15 and delivery of targeted dementia training programme in 14-15 and 15-16 (dependent on funding)
- Developing plans for service improvement, development and commissioning in Wandsworth homecare and care homes by reviewing and identify current gaps in provision and pathways with homecare and care homes in order to reduce and/or avoid admission to hospital through better homecare and care home provision and pathways
- Review of older people's liaison psychiatry provision within acute care
- Delivery of Specialist Clinical Dementia Lead/nurses within primary care to enable people to live well for longer and within their own homes
- Performance monitoring of KPIs within MH contract to ensure effective discharge planning for admitted Wandsworth patients to OPMH wards to avoid delays, that people are only admitted to inpatient OPMH ward following consideration of all the options and the minimum length of stay (LOS) for Wandsworth patients admitted for assessment and treatment episodes within OPMH ward.
- Review in 2014-15 and evaluation of memory assessment service in 2015-2016.
- Mapping and redesigning End of Life care pathways for people with dementia
- Review delivery, performance and effectiveness of reconfigured Community Mental Health Teams for older people as detailed within revised service specification
- Review of performance of current self- management provision and future need to inform future commissioning to improve the quality and effectiveness of services and avoid duplication

3.13 Mental Health CRG

The MH Clinical Reference Group has developed a work programme that has been split into the following key areas:

- Prevention and promotion of Wellbeing
- Quality
- Specialised/Cross cutting pathways

The work programme is reviewed by the MHCRG as a standing item with the following areas prioritised for action:

- BME representation in MH secondary care services

- Review of Talking Therapies
- Service User and Carer
- Review of best practice for common mental health disorders in primary care

Furthermore specific Commissioning Intentions for the SWLSTG MH Trust (the majority MH provider) have been developed both locally and across the SWL Cluster and these also include alongside those above:

- Developing better access to IAPT and Big White Wall (link to Talking Therapies review)
- Development of new model of residential rehabilitation. Both through Hospital hostels and community rehab support.
- Development and mainstream of SUN project for people with personality disorders (Cluster wide)
- CMHT review (link to Quality theme above within work programme)
- Tier 4 and Estates strategy work (Cluster wide)
- Review of out of area placements (Cluster wide)
- Older Adults Tier 4 provision – liaison psychiatry at St. Georges, Discharge planning strategy work
- Older Adults Community provision – Older Adult CRG work plan to redesign services for older adults with functional MH and Dementia. Reconfigured OA CMHT and Memory Assessment Service.
- MH services for veterans and families (Cluster wide)
- Adult ADHD service – develop local pilot
- MHLD – review of patient pathway
- Talking Therapy review (see above priority action)
- BME representation (see above priority action)
- MH Tariff – shadow year 14/15, preparation for go live 15/16. Work with cluster colleagues and SWLSTG to develop an appropriate tariff for Wandsworth (cluster wide tariff?)
- Choice in MH services (Cluster wide) – consider against guidance produced

3.14 Children's Services

The Children's CRG work plan is outlined below and involves work in the following areas.

- Female Genital Mutilation
- CAMHS /PHSE
- Teenage Pregnancy
- Childhood Obesity
- Health Visiting / Health Improvement Plan
- School Nursing
- Community Paediatrics
- Immunisations
- Child Accidents
- SEN Reforms Sept 14
- Commissioning in Special Schools

In addition to the above work streams there are further commissioning intentions outlined below.

- CAMHS Service Redesign to support the new Access Service by the development of clinical session by session outcome measures by 14/15

- Single Point of Access – Children with Disabilities. This will simplify the access to services for children with complex needs for parents and professionals
- The commissioning of Special Schools is currently being reviewed and it is expected that a report will be completed with key recommendations for commissioners in October 2014. This will inform commissioning arrangements in 2015.
- The implementation of the SEN reforms will lead to new commissioning arrangements for children with Disabilities. It is anticipated that to meet its statutory responsibilities that the CCG will have to commission additional clinical resources in 2015/16 e.g. Designated Officer role.
- The Health Needs of Children Looked After are currently being reviewed and this may lead to new commissioning arrangements in 2015/16.
- Phlebotomy Service- Service available for children in three sites across Wandsworth. This service reduces hospital admissions is cost effective and provides good clinical pathway to services for Wandsworth Children.
- Speech and Language service for Children in Secondary Schools. New service development to meet an unmet need in Wandsworth.
- Feeding Service Children 0-5 – This service covers a previously unmet need in Wandsworth for a service for children 0-5 who have feeding or swallowing problems.
- Place 2 Be-Early intervention Counselling service for children and parents in Primary Schools.
- NICE Compliance children with ASD / ADHD. CCG investment to ensure that the CAMHS, ADHD and ASD teams are NICE compliant.
- Increased Occupational Therapy resource to support children with Disabilities. OT services are under resourced to support this vulnerable group of children.
- CABIN pilot may develop a new method for reducing admissions for children with minor infections by 2015. This may lead to new cost effective commissioning arrangements from April 2015

3.15 Falls and Bone Health CRG

Under the new Health and Social Care Act (2012), Wandsworth CCG and LA are responsible for the commissioning of falls prevention, management and bone health services. Statutory responsibility for commissioning falls prevention, management and bone health services transferred from the previous Wandsworth Primary Care Trust (PCT) to Wandsworth Borough Council and Wandsworth Clinical Commissioning Group on 1 April 2013.

The Falls Prevention, Management and Bone Health Clinical Reference Group will therefore:

- Work with Wandsworth Local Authority through the Integration Transformation Fund and Joint Health and Wellbeing Board to:
- Implement the CCG's and Local Authority joint strategic intentions in commissioning falls prevention, management and bone health services, through pooled budget arrangements in the areas of most need. All commissioned services will be in line with the National Institute for Health and Clinical Excellence (NICE) guidance and the two statutory bodies will engage with patients and the public to improve outcomes for people at risk of falling and those who have already sustained a fall as well as those with, or at risk of developing poor bone health in Wandsworth.
- Implement the CCG's strategic intentions in terms of the commissioning and on-going monitoring of services for the prevention and treatment of falls and

fractures and the maintenance of bone health in older people within Wandsworth
- Work with NHS England to support improvements in primary care services

Having invested approximately £800,000 in falls and bone health services in 2013/14, we will develop, as part of the Out of Hospital Strategy, a proposal for 2014/15 that will enable the CCG to:

Integrated services

- Commission an integrated Fracture Liaison Service (both within the acute and community) which proactively case finds patients who have had fragility fractures in the past or are at risk of osteoporotic fractures. The Fracture Liaison Service will also investigate bone density, start drug and other treatments to reduce the risk of a future break, liaise directly with falls services and monitor and maintain medication adherence;
- Ensure patients who have sustained a fall in the past year and/or are concerned about falling in the future, receive falls risk assessments and are referred into evidence based falls prevention exercise programmes where appropriate;
- Ensure patients who have sustained a fragility fracture are offered a bone health programme which offers education, assessment and exercise classes to appropriate patients;
- Continue the growth in appropriate referrals to the Integrated Falls and Bone Health service and ensure that Satellite Falls and Bone Health clinics are available in a wider number of community venues
- Ensure pharmaceutical provision is available within the community to support medicine use and compliance, in particular relation to patients with bone health conditions;
- Commission a handyperson service to ensure older people living in Wandsworth remain safe and secure in their home environment and are able to maintain independent living for as long as possible

Acute services

- Commission appropriate diagnostic services (e.g. DEXA scanning facilities) for Wandsworth patients
- Work with local acute providers to implement NICE clinical guideline 161 falls: assessment and prevention of falls in older people with particular focus on the new recommendations that were introduced in 2013.
- Work with the Referral Management team to commission the use of Kinesis to support appropriate bone health referrals into local acute trusts

Primary Care

- Sustain the work that has been initiated in 2013/14 to identify patients within GP practice who are at risk of a future fall and/or fracture to ensure that identification and management of these patients becomes routine practice
- Commission community pharmacies to provide an enhanced Medicine Use Review (MURs) service focusing on falls and bone health

Voluntary Sector

- Commission an evaluation of the Wandsworth Housing Adaptations and Repairs Forum (WHARF) coordination service with a view to informing future commissioning arrangements
- Ensure that a single point of contact service is available to frontline health and social services professionals to support vulnerable individuals at risk of falls to signpost and refer on to falls prevention and housing services

Medicine Management

- Enable the commissioning of denosumab (currently a hospital only prescribed drug) to be prescribed within the community
- Ensure individuals who have sustained a fragility fracture are prescribed appropriate bone health medication

London Ambulance Service

- Work closely with the London Ambulance Service to ensure that fallers are identified by ambulance personnel and referred into local falls teams for early intervention

Telecare

- Work closely with Wandsworth Borough Council Telecare and WATCH service to ensure that fallers are identified by Telecare and WATCH services and referred into local falls teams for early intervention

Training

- Commission bespoke training where appropriate to support professionals in providing good management and to further support the implementation of the falls prevention, management and bone health pathway

Communication and Engagement

- Improve awareness of falls prevention, management and bone health through communication and engagement with health and social care professionals, local voluntary sector groups as well as the public, patients and their carers

Cross working

- Work alongside the Care Homes CRG *(please note that this has yet to be developed)* to commission falls prevention, management and bone health services within care and residential homes

Work alongside the Dementia and Alcohol CRG to commission falls prevention, management and bone health services which are appropriate to these individuals

3.16 Cardiovascular Disease CRG

The CVD Clinical Reference Group (CRG) will develop, as part of the Out of Hospital strategy, a proposal for 2014/15 that will enable the CCG to:

- Investigate the possibility of developing a standardised CVD assessment and associated template that can be used within primary and secondary care to ensure that any patient in primary or secondary care presenting with a CVD

diagnosis is proactively assessed for the existence of other CVD risk factors e.g. hypertension; hypercholesterolemia; coronary heart disease; stroke; type 2 diabetes; kidney disease and peripheral arterial disease

- Support Wandsworth Local Authority through the CRG and Localities to encourage the local population to adopt healthier lifestyles

- Sustain the work that has been initiated in 2013/14 to identify patients who are at risk of developing Chronic Kidney Disease (CKD) to ensure that identification and management of these patients to prevent deterioration of condition becomes routine practice

- Review and implement the local Familial Hypercholesterolemia (FH) guidelines to improve the identification of individuals and families at very high risk
- Support primary care to provide good management of people with or at risk of CVD by commissioning:
    - Appropriate diagnostic services for Wandsworth patients
    - Bespoke training where appropriate to support the healthcare professionals to provide good management
    - Improve awareness of cardiopulmonary resuscitation (CPR) by conducting the following audits within:
        - Primary care to establish a list of Wandsworth GP practices who have access to defibrillators
        - The CCG workplace to establish a list of staff that are trained in cardiopulmonary resuscitation (CPR) and basic life support skills training
- Work with the Wandsworth Self-Management team to commission appropriate self-management programmes, which enable patients and their carers to feel empowered and supported to live as full a life as possible after diagnosis or an acute event.
- Improve assessment and care planning for patients and their carers

Work closely with the End of Life Care (EOLC) CRG to improve care for all those approaching the end of life

3.17 Wandsworth Self-Management Service (WSMS)

Last year, the programme formerly known as WSMP, now known as WSMS, committed to delivering a number of actions as part of its commission intentions, these are as follows;

- Easy to access Information and knowledge resources

- Self-management training (SMT) for the public

- Supporting self-management training for professionals

- Condition specific training for professionals and the public – lived experience

- learning

- Engaging with other sectors to integrate capacity and capability e.g.

    - community and voluntary sector
- Peer support through self-help and communities
- Utilisation of technologies to connect people and systems

Service organisational change to engage with all of the above

3.18 End of Life Care

Last year, the EOLC CRG highlighted its plan to develop 2 key initiatives:

1. An EOLC Coordination Hub to oversee and facilitate the step-up/step-down coordination of holistic (physical, psychological and social/domestic) care for EOLC patients in the community, based on individual need;

2. A new Health Care Assistant (HCA) role combining both "nursing" and domiciliary/personal care duties, (initially) for patients who meet the fast-track continuing care criteria (normally a prognosis of maximum 12 weeks). The aim of role is to provide a range of "nursing" care duties as well as incorporate the personal care/domiciliary duties currently undertaken via Continuing Care commissioned agency carers.

Both developments are designed, through better coordination and utilisation of services and resources, to provide more joined-up care for this group of patients, thereby preventing avoidable hospital admissions and unnecessary interventions and enabling people to be cared for and die in the place of their choice.

4. 2014/15 Commissioning Intentions Delivered

4.1 West Wandsworth Locality

Mental Health

The locality has been working with Public Health to launch the Mood Manager DVD pilot. The DVD has been developed to enable people to play a more active role in managing their depression. It provides information to increase awareness of the condition, increase compliance with medication and provides advice to encourage enhanced physical health and wellbeing. The latest version is available in six languages and will be launched to practices in July. GPs will distribute the DVD to appropriate patients, encouraging them to provide feedback on how helpful the DVD has been. Public Health will carry out an evaluation of this pilot to assess its impact.

Family Action provides an early intervention mental health service across the borough. In West Wandsworth the locality worked with Family Action to set up this service in a local surgery, and the service has been running since September 2013 accepting referrals from all the local practices.

Big White Wall presented at Members Forum in November 2013 to promote their service, especially the new initiative of GPs being able to directly refer patient to live therapy. This led to more practices in the locality signing up to be able to refer patients to this service.

The Locality is currently working with the Community Mental Health Team (CMHT) for Putney and Roehampton to identify ways of improving the physical health of those with mental health disorders.

Cardiovascular disease

Parts of West Wandsworth, especially Roehampton, are areas of high CVD risk. Therefore it was identified there would be an increased benefit for this population to attend for NHS Health Checks.

In 2013-14 eight practices signed up to continue to deliver NHS Health Checks, achieving 81% of the locality target. There was significant variation across practices in the level of Health Checks delivered, from 15% of to 111% of target. To support delivery of Health Checks a mobile clinic has been funded by Public Health in Roehampton and Putney Heath, undertaking 50 checks last year.

A near patient testing pilot for NHS Health Checks has also been undertaken and evaluated with the aim of improving uptake. The LDX machine has the potential to provide for more flexibility in provision, as patients do not need to attend a fasting blood test prior to their appointment. The pilot has been extended for six months to further refine it. This continues to be a priority area and West Wandsworth is keen to focus on achieving these targets through joint working to deliver this service.

Healthy Schools

The locality worked with the Local Authority to develop a proposal for GPs going into schools to meet with staff and explore what work around health was already undertaken and what issues they had. This presents an ideal opportunity to co-ordinate key health messages being delivered within the school curriculum or healthy schools programme supporting the role of the school nurse. The Management Team will be meeting with the School Nursing Team to discuss the outcomes from the visits and to look at how they can work together more closely.

A number of GPs and schools expressed an interest in taking part in this pilot and to date two successful visits to primary schools have been completed, with plans to expand the programme and carry out further visits. Following the initial visit one of the schools has asked the GP to talk to their Reception class about visiting the doctor.

The locality has also provided feedback and input into the new school nursing specification.

Sexual Health

West Wandsworth worked with the Public Health sexual health lead to produce an awareness raising campaign for practices. A factsheet was developed providing an overview of the sexual health services primary care can offer. Most practices are now providing Chlamydia screening; five are providing long acting reversible contraception services and one HIV testing. The use of condoms is being promoted to support the reduction of teenage pregnancies and STI's in 'at risk' groups.

Cancer

As part of its cancer priority it was agreed that each practice would meet with the Macmillan GP Facilitator to discuss cancer referrals and diagnosis; areas where there is potential for improvement, safety netting and the Cancer Care Review. Over the past year six practices have held these meetings, resulting in greater awareness and improved systems in practices for managing two-week referrals and ensuring these patients are followed up. These visits will be continuing.

Engagement

West Wandsworth has an active Locality Patient Consultative Group, currently formed of members from five practice's patient groups. The group developed its own action plan, which included support to practices to develop their patient groups, and engaging with key priority areas such as Queen Mary's Hospital, and the Clinical Reference Groups.

The group has had a range of speakers on topics including Mental Health, Children's Services, Weight Management, Domestic Violence and the Roehampton Regeneration. The group has a specific interest in mental health.

The group raised concerns about the NHS 111 service and following meetings with the CCG it was agreed that the Putneymead Patient Group would carry out a survey of patients who had used the service. This was carried out between August 2013 and January 2014 and a full report on the survey outcomes was submitted to the CCG for review.

The Chairs from the three locality patient groups meet on a regular basis with the locality managers. It was agreed that a joint event should be held to bring the three locality patient groups together. The event was held in February 2014. An overview of each locality was followed by group work focusing on what makes a good patient group; what works well in practice and locality patient groups and what could be improved. All those who attended gave positive feedback and it is hoped another joint locality patient group will be held event later this year.

Over the last two years GPs have been encouraged to visit Seldom Heard Groups, to create links and further understand the role of these groups and how they may be beneficial to their patients. A wide variety of groups have been visited by the locality GPs.

4.2 Wandle Locality

Advice and Community Referral Service

Members chose to extend the pilot advisory service that had operated at two Wandle Practices under the FURs scheme. The extended pilot service aims to enable all Wandle practices to 'prescribe' community advice with onward referrals where appropriate to their patients. The service aims to de-medicalise patients' social support needs, improving the quality and timeliness of advice received and improving the appropriateness of primary care contacts.

- The service anticipates up to 500 referrals from Wandle GPs over the nine month pilot
- After the practice referral, patients are contacted by either telephone or email
- Six practices spread geographically across the locality have volunteered to offer space if follow up face-to-face appointments for the service are required
- The service was soft-launched on 1st July and went fully live on the 23rd July.
- A full evaluation of the service will be carried out

A+E attendances

Reducing inappropriate A&E attendances is a key priority for Wandle. Under the Quality Productivity work stream, all practices developed an action plan of how they were addressing this.

Actions implemented by practices included:

- Increase usage of the Community Ward
- Increased flexibility and access for on call doctors
- Increasing telephone consultations
- Identifying and reviewing frequent attenders
- Introducing walk-in services at key times of the day
- Better use of community services
- Improved education to staff and patients

4.3 Battersea Locality

Members Development Programme

The 2014-15 Members' Development Programme has provided further opportunities for GPs in Battersea to develop themselves as commissioners and support their development.

Productive GP Programme

In 2013-14 all practices in Wandsworth CCG were given the opportunity to undertake the Productive GP Programme in order to develop themselves into more efficient practices and therefore provide higher quality care and services to their patients.

7 of the 12 Battersea practices signed up to the programme which has delivered some great success with some practices and lead to improvements in others. Over the course of the year these practices will collate data to demonstrate the improvements they have realised.

Stress Management Programme

With agreement from the BLCG Members and Patient Consultative Group, Battersea Yoga have been commissioned to provide a Mindfulness Course for all Battersea Patients. This course has the support of 100 per cent of the locality member practices and enables the GPs and nurses to refer patients to this course, targeting those patients who would benefit from this support and as a result reduce their attendance at the practice, at local Accident and Emergency departments or other urgent care services. The administration of the course is provided by Thurleigh Road practice, which enables a close connection with the local clinicians and supports a 2-way referral mechanism where concerns over patients at the course can be referred back to their GP. This is equally relevant to patients from all demographics.

Parenting Programme

In order to support new parents in Battersea, the parenting programme has set up three hub sites in areas with a high birth rate ensuring improved accessibility to these support classes essential to improve the healthcare of new born babies. The programme will also support the up-skilling of parents to ensure they seek the most appropriate services to support their baby and themselves. This is again equally relevant to patients from all demographics.

The programme has 100 per cent support from BLCG members and the programme is already up and running in one of the three sites, based in a local GP practice. The other two sites are located in non-clinical hubs, to monitor the variation in benefit of hosting these programmes in either GP or non-GP locations.

Condoms, Chlamydia, and HIV project

Working in close collaboration with Wandsworth Public Health, Terrance Higgins Trust, Metro and Wendy Majewska (HIV Trainer), BLCG members have developed a bespoke training and education programme adapting the national 3C's and HIV project to ensure it delivers the most efficient and appropriate care for Battersea patients.

All practices have signed up to the programme and have or are scheduled to receive training from Terrance Higgins Trust, Metro and Wendy Majewska.

Practices will receive support throughout the course of the programme from Dr Ray-Chowdhury, the project Clinical Lead. The challenges have been how to include staff training and engagement and working better with the local GUM and family planning services. By enabling this as a whole practice training programme, this will ensure patients receive the best advice, support and service from reception to clinicians.

School Nursing Letters

All children have their height and weight measured in reception and year 6. Parents are sent a letter outlining the results, including the weight category their child is in (underweight/healthy weight/overweight/ very overweight). The School Health and Nursing team are conducting the measurements and follow up of children in year 6 who have been identified as obese to provide support and signposting to services. All National Child Measurement Programme (NCMP) letters outlining results of height and weight measurements of children in school are now automatically copied to GPs for review and onward management. GPs opportunistically identify obese adults who visit the surgery with their children, offering encouragement and support to reduce barriers to referral and referring families with overweight children to Wandsworth healthy weight programmes.

4.4 Primary Care

Delivery of our intentions in 2014/15 has been on 3 main fronts:

1. Delivery of a series of enhanced services including diagnostics, extended opening hours and our innovative planning all care together contract at General Practices across the Borough
2. Enhancing the quality of primary care through our membership development programme and the launch of a practice support team
3. Development of the primary care workforce through a programme of education, improved communication and shared best practice

4.5 Community Adult Health Services (CAHS) Redesign

The implementation of the CAHS model is key as this is the vehicle for delivering all of the other schemes effectively; the CAHS model promotes a way of working which focuses on delivering effective and seamless communication amongst health care professionals within

the Community based multidisciplinary team. The Provider has agreed to work with the CCG over the next two years to implement the model with clearly defined milestones for implementation.

The CCG has established a monthly Steering Group for Transforming Community Services which is responsible for monitoring the implementation plan. In addition to the Steering group the CCG has established the following processes to monitor delivery of the Community services contract:

The implementation of the newly redesigned Community Adult Health Services (CAHS):

- A Risk and Issues register is shared by the Provider to outline medium-high risks and the approach taken to mitigate these risks.
- A monthly Clinical Commissioning Reference Group (CCRG) meeting is responsible for reviewing the contractual delivery through clinical Key performance indicators and ultimately taking expedient and necessary action to liaise with the contracting team if there is a risk that the provider cannot adhere to their contractual obligations.
- A monthly Clinical Quality Reference Group (CQRG) is responsible for monitoring the quality of the service as the Provider implements the model of care.
- The Provider has identified the four Locality Hubs where the Access and Coordination hub will be based and in addition where the weekly MDT will be based. The four locality hubs are the heart of the CAHS model and are pivotal to the successful operation of Community services. The Access and Coordination hub went 'live' in July 2014.

Rapid Response Pathway (Phase 1 of pilot)

- The Rapid Response Carers service was commenced in May 2014 and was commissioned through the Better Care Fund (BCF) to provide a rapid response pathway to activate care packages within 4 hours. The intention of the care package was to support patients with social care needs in order to prevent patients being admitted unnecessarily due to an overriding social care breakdown. For the purposes of this 6 month pilot an independent care agency (Holistic) has been commissioned to provide this service.

Health Education for South London (HESL) bid for scoping educational need for staff in nursing and residential homes in Wandsworth

- Following the successful bid to HESL, Wandsworth CCG have secured financial support to appoint x2 Band 7 nurses to work alongside Community services to scope out the educational gaps for staff in terms of confidence and competence to manage patients effectively with long term conditions. This also includes working with the homes to identify suitable patients that may benefit from Telehealth monitoring to manage patients with long term conditions. The project managers leading this project have organised a meeting to meet with Nursing/residential home managers in Wandsworth to outline the premise of this work and the outcomes the CCG hopes to achieve over the forthcoming year. The homes have been extremely receptive and are looking forward to working collaboratively with the CCG to identify opportunities to develop their staff further in order to equip them with the confidence and a

competence framework to manage patients with long term conditions. Post holders have been successfully appointed and will take up post from 15th September 2014.

The CCG will monitor performance through the QUIPP and delivering on the Out of Hospital plan.

The CCG will also monitor SUS data and work closely with GE Finnamore in monitoring the out of hospital plan.

The overall successful implementation of the above approaches and defined pathways to working should result and reflect in an overall reduction in the following areas for the over 75 year's population living in the borough of Wandsworth:

- Reduction in length of stay
- Reduction in A&E attendances
- Reduction in Outpatient attendances
- Reduction in Non-elective admissions (? 3.5% on 2012/2013 NEL admissions rates)

4.6 Cancer CRG

- PACT:
  - Holistic review for patients within 5 years of a diagnosis of cancer
  - Stable haematology
  - Bowel cancer screening
- Review of best practice pathways: ovarian cancer pathway agreed
- Exercise on Prescription for patients with a diagnosis of cancer
- Practice Nurse Training for cancer
- General Practice Engagement/Education and Macmillan GP Facilitator
- Practice Lead for Cancer via Federation
- Self-management for Patients with cancer through Pauls Cancer Centre
- Practice Lead for Cancer
- PPI: recruitment of patient representatives, WHIZ event, Get to Know Cancer Event
- GP education event
- Health and Well-being Clinics

4.7 111 and OOH CRG (urgent care systems)

- Review of St. George's urgent care centre being delivered by Finnamore consultants.
- Launch of Single Point of Contact with special access code for known patients to community services (September 2013)
- Review Capacity of OoH PCCs including UCC
- Implementation of Improving Primary Care Access LES
- Ensuring quality an safety standards with Provider through 111& OoH CQRG
- PACT Contract: OoH GP Patient Leaflet; Special Patient Notes Referral form; SPoC Referral form
- CAHS redesign supporting SPoC as locality structure : access and co-ordination hubs
- PPI: 111 and OoH provider attending patient locality meetings to raise awareness; Wandsworth patents involved in NHSE organised workshops relating to future 111 procurement

4.8 Diabetes CRG

St George's Healthcare NHS Trust has been running a pilot tier 3 community clinic at St John's Therapy Centre since October 2013. This has recently been evaluated in terms of efficiency and productivity. Discussions are now underway to agree the details that will enable other clinics to be opened. This work will be aligned to the wider implementation of the redesigned Community Adult Health Services.

Workshop held that was attended by clinicians, managers and patients to review various qualitative and quantitative data. As a result, various areas of focus were identified that have informed the 5 and 2 year plans for the CRG as well as the 2014/15 Annual Work Programme.

One of the QP work streams was for GP practices to review the delivery of foot care to patients and how robustly the referral criteria to specialised podiatry are followed. EMIS search criteria were devised and a list of patients provided to each practice to review. Educational workshops were also provided to clinical staff to support this. Overall this work was successful in raising awareness of how important the foot assessment is for patients with diabetes.

4.9 Respiratory CRG

- We have undertaken a review of the Asthma Services
- The Community Respiratory Nursing Capacity was increased as part of the CAHS redesign programme
- A number of training programme have been delivered and will continue to be delivered throughout the year
- Pulmonary Rehab service has had additional funding for the next two years to increase the capacity of the service and implement a community pulmonary rehab service.
- The pilot Tier 3 consultant led clinic at QMH is in place for 6 months as part of a CQUIN with St Georges.

4.10 Locality Stroke and Neuro Rehabilitation CRG

This is all linked to the OOH strategy plan. This group was a newly formed in January 2014 therefore a lot of work has been focused on developing priorities for the delivery of the OOH strategy. We are currently delivering the Sis Month Review and Stroke Information, Advice and Support programme as a pilot programme while we look to develop contracting arrangements for 2015/16 onwards.

A mapping exercise of current stroke services and their pathways has been undertaken.

4.11 Dementia CRG

- Behaviour and communication support service. Business case approved. Funding and phased implementation agreed. First phase of roll out complete – whereby service is now operating in 6 out of the 15 care homes.
- Current picture of dementia training across Wandsworth mapped. Dementia training needs identified across Wandsworth health and social care system and voluntary sector (will complete by end of 14 - 15)
- Review of the Memory Assessment Service to ensure service is able to meet demand and review performance (will complete in 14 – 15)
- Consultation, review of good practice / evidence and draft specification completed for new posts of Specialist Clinical Dementia Lead and dementia

clinical nurse specialists within primary care to enable people to live well for longer and within their own homes

4.12 Mental Health CRG

There has been significant progress on the key areas, which is captured here as an update of current position and actions achieved.

- BME representation in MH secondary care services – Working group with solid stakeholder involvement has met regularly throughout 2014/15 and continues to meet. Demographic & Service data has been collated alongside a range of national and local evidence bases. Key themes have been identified of prevention/wellbeing, early intervention, assessment & admission and discharge. From these an Action Plan for key actions is being developed as the group work programme into 2015/16 (see Intentions in Process). The CCG has commissioned the Community Network for Family Care in 2014/15 as an initial response to this work.

- Review of Talking Therapies – Review report delivered. Action Plan to meet recommendations produced, delivery and oversight of which through the MH CRG. The Action Plan is linked to improving access and reducing waiting times, whilst sustaining targeted recovery rates.

- Service User and Carer Experience – MHCRG retained focus on the existing Foundation Trust metric/target with SWLSTG, building on current progress (development of SURG; co-production actions and improved involvement for Carers and Families in care planning)

- Review of best practice for common mental health disorders in primary care – GP Leads commence consideration of Stepped Model of Care & ensure appropriate links to Psychological Therapies Review.

- Development of new model of residential rehabilitation. New model implemented in June 2014.

- Debt management and Mental Health – literature review produced.

- Suicide Prevention – Working group established and reporting progress to MH CRG.

- Delivery of Mental Joint Commissioning Plan.

- Needs Assessment – completed and included in MH Joint Commissioning Strategy

- Review of out of area placements (Cluster wide) – contributed to cluster investigation. Locally have implemented revised NHS contract and specification for all out of area placements, ensuring quality assurance and monitoring mechanisms in place.

- Older Adults Community provision – Older Adult CRG work plan to redesign services for older adults with functional MH and Dementia. Reconfigured OA CMHT and Memory Assessment Service.

- Adult ADHD service – local pilot being scoped with SWLSTG

- Dual Diagnosis (MHLD) – review of provision in progress.

- Dual Diagnosis (substance misuse) – key input into Substance Misuse re-tender work.

- MH Tariff – shadow year 14/15, preparation for go live 15/16. Continued work with cluster colleagues and SWLSTG to develop an appropriate cluster wide tariff.

- Choice in MH services (Cluster wide) – await guidance through cluster leads.

- Perinatal Services – review of perinatal services complete. Action plan developed including proposals to re-shape current services to improve pathway and outreach potential.

- CAMHS restructure – see YP CRG intentions.

4.13 Children's Services

- Revised CAMHS commissioning. The new Access service has started and significant progress has been made. Waiting times for the service have reduced are now at 2-4 weeks .Referrals to Specialist CAMHS have also reduced. The service has been positively cited in the recent Home Office Peer Group Review in Feb 14and Has received a SWLSTG Partnership and Integration award in May 14
- Single Point of Access – Children with Disabilities. This work started in shadow form in Feb 14 and was fully launched in March – April 14.This service has streamlined the referral pathway for parents and professionals and the benefits of this investment will be realised throughout 14/15.
- Phlebotomy Service. This service reduces the need for hospital admission for children by providing blood tests/ investigation. There is now a clear clinical pathway for taking the bloods of children across Wandsworth, Sutton and Merton. There are now community sites in Thurleigh Road and Balham Surgeries. Additional services have been set up at St Johns Therapy centre and SGH.
- Speech and Language service for Children in Secondary Schools. This service has commenced and the number of secondary school children now receiving SALT has increased. The service also provides training for the teaching staff in the early identification of SALT problems in the secondary schools and has trained over 150 teachers
- Feeding Service Children 0-5. This service has started and there are 3 sites that are set up and operating across Wandsworth.
- Place 2 Be Counselling service for children and parents in Primary Schools. This service has started and has produced some very positive outcomes for the children and families using the service
- NICE Compliance children with ASD / ADHD. Investment into services for children under 7 years and over has been increased and the waiting times for ADHD / ASD in Wandsworth are reduced so the service is now NICE compliant. The services are provided by SGH and the Specialist CAMHS team.

- Increased Occupational Therapy resource to support children with Disabilities. This service has commenced and there are now more clinical resources to support this vulnerable group of children.

4.14 Falls and Bone Health CRG

Wandsworth CCG and Borough Council jointly commissioned the following services:

- An acute based Fracture Liaison Service which proactively case finds patients who have had fragility fractures in the past or are at risk of osteoporotic fractures. The service also investigates bone density, starts drug and other treatments to reduce the risk of a future break, liaises directly with falls services and monitor and maintains medication adherence

- A community based Integrated Falls and Bone Health service delivered within Satellite Falls and Bone Health clinics across the borough which ensures:
    - patients who have sustained a fall in the past year and/or are concerned about falling in the future, receive falls risk assessments and are referred into evidence based falls prevention exercise programmes where appropriate;
    - patients who have sustained a fragility fracture are offered a bone health programme which offers education, assessment and exercise classes to appropriate patients;
    - pharmaceutical provision is available within the community to support medicine use and compliance, in particular relation to patients with bone health conditions;

Wandsworth CCG has commissioned the following services:

- appropriate diagnostic services (e.g. DEXA scanning facilities) for Wandsworth patients;
- falls and fracture risk assessment and identification as part of the GP Planning All Care Together (PACT) contract to ensure that patients at risk of a future fall and/or fracture are identified and managed appropriately;
- a single point of contact (WHARF Coordination service) for frontline health and social services professionals to support vulnerable individuals at risk of falls to signpost and refer on to falls prevention and housing services;
- a handyperson service to ensure older people living in Wandsworth remain safe and secure in their home environment and are able to maintain independent living for as long as possible.

4.15 Cardiovascular Disease CRG

Support Wandsworth Local Authority through the CRG and Localities to encourage the local population to adopt healthier lifestyles

- A supervised exercise programme for patients living with peripheral arterial disease has been commissioned and was promoted as part of the QOF QP pathway development initiative. A significant number of patients were identified and referred into the new service;

- Wandsworth continues to be above the national target in terms of patients being invited and taking up the offer to have an NHS Health Check. The programme is being marketed through GPs, pharmacies and Solutions4Health an outreach provider.

Sustain the work that has been initiated in 2013/14 to identify patients who are at risk of developing Chronic Kidney Disease (CKD) to ensure that identification and management of these patients to prevent deterioration of condition becomes routine practice.

- EMIS searches and audit requirements were established but following a period of testing, it was established that the EMIS searches did not enable primary care staff to identify all appropriate patients. A development request was submitted to EMIS to fix the problem but no response has been received. As a result, the CRG has taken the decision to stop this initiative.

Support primary care to provide good management of people with or at risk of CVD by commissioning:

- The British Heart Foundation were commissioned to deliver a series of training sessions for primary care professionals

- Service review has been undertaken on the existing diagnostic services being delivered within primary care with a view to influencing future commissioning arrangements

- There is a defibrillator within the CCG HQ. Staff received basic training on cardiopulmonary resuscitation (CPR) to support the use of the defibrillator.

To commission appropriate self-management programmes, which enable patients and their carers to feel empowered and supported to live as full a life as possible after diagnosis or an acute event:

- An IAPT service specifically for patients with long term conditions has been commissioned. Service provider attended a CRG meeting to provide further information on the service available to patients with coronary heart disease and to encourage referrals into the service.

4.16 Wandsworth Self-Management Service (WSMS)

Delivery on 14/15 commissioning intentions are as follows;

- Care4me has been developed to create a single portal of easy to access information and resources.
- The Expert Patients Programme has and will continue to be used as a key delivery tool for providing the public with self-management training.
- A continued effort is being made to engage with both community and voluntary sector organisations; thus far the team have met with the Housing Department, Springfield Hospital and Health Watch Wandsworth. This piece of work will be continuing throughout the year.
- Lifetimes, through care4me, have been helping the development of self-help groups and providing information to those who wish to start their own group. Peer support is also being offered through opportunities to volunteer for organisations as a form of work experience.

The service has changed since last year, which will now include the Wandsworth Hub and Social Prescribing. Through these 2 additional services, WSMS have been able to utilise new technologies to make services easier to access and make information more readily available.

4.17 End of Life Care

The service has changed since last year, which will now include the Wandsworth Hub and Social Prescribing. Through these 2 additional services, WSMS have been able to utilise new technologies to make services easier to access and make information more readily available

Plans for both projects highlighted above have been developed and funding agreed for a 2 year pilot project. Trinity Hospice has been commissioned to implement and deliver both pilot initiatives (ie the Hub and the HCA service). Work is underway, overseen by a multi-stakeholder Project Board, to develop the detailed operational plans with a view to go-live early in 2015.

5. 2014/15 Commissioning Intentions in Process

5.1 West Wandsworth Locality

Work is still continuing on the following:

- Mental Health
- CVD
- Healthy Schools
- Patient and Public Engagement
- Sexual Health
- Cancer Diagnosis

Healthy Schools

This project will continue, and expand on, the work already done in the locality around working with schools and the school nursing team. The aim is to improve communication, co-ordinate key health messages and improve care.

Cardiovascular disease

- NHS Health Checks – To implement an alternative model of delivery through working collaboratively, ensuring all patients have the opportunity to access this service
- BP campaign – To complement the delivery of NHS Health Checks the majority of practices now have waiting room Blood Pressure machines. Practices will be provided with protocols and guidance on how to make the most of the machines, and patient information to be displayed alongside the machines

Mental Health

- Physical health – To work with the Putney and Roehampton Community Mental Health Team to develop a proposal to improve the physical health of those with mental health conditions
- Mindfulness – To work with the Wandsworth IAPT service to pilot Mindfulness course. It is proposed to run four courses over the next few months. This proposal came from the

Locality Patient Group, which is working with the locality to further develop and deliver this scheme

- Sleep disorders – To work with Wandsworth IAPT to develop and pilot a series of sleep education workshops for patients with sleep disorders

5.2 Wandle Locality

Obesity - BMI Measurement with pre-school immunisation booster

As obesity is one of Wandle's key priorities, a proposal has been put forward for Nurses and HCAs to measure children's Body Mass Index (BMI) when they attend for their pre-school immunisation booster. The proposal includes:

- Training for health care professionals on the technicalities of measuring BMI in children and how to discuss the issue of child obesity in an effective, compassionate and motivating way
- Provision of BMI charts to practices
- Information sessions run at key practices across Wandle where parents could receive advice on healthy eating, physical activity, behaviour change and local weight management services

Seldom Heard Groups

A GP representative from each Wandle Practice is undertaking a visit to a Seldom Heard or Community Group. These visits help our commissioning GPs to understand the health and social care needs of the group, explore how health promotion messages could be better spread and ensure that a wider patient voice is heard. Groups visited by Wandle GPs this year included Thomas Pocklington Trust, Cedar House Support Group, Community Matters and the Asian Women's Association.

Diabetes

Wandle residents are at higher risk, compared to the Wandsworth average, of developing diabetes. Wandle is leading an audit of undiagnosed patients as it is believed there are around approx 1,500 people in Wandsworth who have diabetes that is either not diagnosed or incorrectly coded and the aim of this exercise is to close the gap between actual prevalence and the estimated prevalence.

COPD

Although Wandle has a relatively low recorded prevalence of COPD, there are a large number of people living in the area who smoke. This suggests that there may be a high number of people living with undiagnosed COPD or who are at significant risk of developing the condition. A target missing millions programme will be rolled out to those practices where it is felt there is a large number of patients with undiagnosed COPD. This is currently being piloted in a practice in Wandle before being rolled out later this year.

5.3 Battersea Locality

Still under implementation are:

- The Patenting Programme – pilot (review March 2015)
- Condoms, Chlamydia and HIV Project – pilot (review March 2015)
- Stress Management Programme – pilot (review March 2015)

- Patient and Public Engagement
- Development of Member Practices
- Awareness initiatives – ensuring practices are aware of and signpost information to patients about current national awareness initiatives

5.4 Primary Care

Over the course of the rest of the year, clinical reference groups will be launching a series of case finding schemes, with the aim of increasing early diagnosis and improved management of patients with long term conditions.

The CCG will also be continuing to explore opportunities for encouraging collaboration between practices, to ensure that all patients across the Borough have access to the same high quality primary care services.

5.5 Community Adult Health Services (CAHS) Redesign

- Work is ongoing to establish the minimum data set that Community services will be required to report on monthly, in conjunction with monitoring the overarching outcome measures to monitor QIPP delivery.
- The CCG are developing an Outcome-Based Commissioning (OBC) approach. The CCG would expect the Provider to work towards, i.e. Clinical effectiveness, service improvement, patient satisfaction and patient safety.
- Critical friends group established
- Patient satisfaction interviews underway
- CAHS/START alignment of health and Social care re-ablement services
- Scoping of bed based services for older people within the acute and Community setting including the use of beds in QMH, RGH, and SGH older people's beds. (see above sections)

5.6 Cancer CRG

- PACT:
    - Holistic review for patients within 5 years of a diagnosis of cancer
    - Stable haematology
    - Bowel cancer screening
- Review of best practice pathways: ovarian cancer pathway agreed
- Exercise on Prescription for patients with a diagnosis of cancer
- Practice Nurse Training for cancer
- General Practice Engagement/Education and Macmillan GP Facilitator
- Practice Lead for Cancer via Federation
- Self-management for Patients with cancer through Pauls Cancer Centre
- GP education event
- Health and Well-being Clinics based at St Georges Hospital and in community settings

5.7 111 and OOH CRG (urgent care systems)

- Urgent care centre model review
- Review Capacity of OoH PCCs including UCC
- Implementation of Improving Primary Care Access LES

- Ensuring quality and safety standards with Provider through 111& OoH CQRG
- PACT Contract: OoH GP Patient Leaflet; Special Patient Notes Referral form; SPoC Referral form. Additions have been made to the PACT contract in 2014/15. For example patients with cancer diagnosis in the last five years and learning disability patients. There has also been an increased focus on GPs completing special patient notes for all patients in cohort 3 and considering it for patients in cohort 2.
- CAHS redesign supporting SPoC as locality structure : access and co-ordination hubs

5.8 Diabetes CRG

The undiagnosed patient audit aims to use risk stratification to close the gap between the actual and expected prevalence. Funding has been ring-fenced to support this work and the audit will commence by the end of September 2014.

5.9 Respiratory CRG

- The missing millions programme is currently in development.
- Opportunities for education continue throughout the year.

5.10 Locality Stroke and Neuro Rehabilitation CRG

- We are currently working on developing a programme to support the identification of people who have had a stroke in Primary Care.
- The Stroke Six month review and information advice and support service are in place until the 31st March 2015. A review of the current community contracts is underway.

5.11 Dementia CRG

- Behaviour and Communication Support Service - a psychology and nurse led team supporting staff teams and residents in enhancing communication and reducing distressed reactions in care homes. Business case approved. Funding and phased implementation agreed. First phase of roll out complete – service operating in 6 of the 15 care homes. Second and third phase roll out planned and to be implemented following capacity review.
- As-is dementia training mapped and needs identified across contracted Wandsworth health &social care system and voluntary sector (will be completed in 14 - 15)
- Full service review of the MAS (will be completed in 14 – 15)
- Delivery of targeted training within Primary Care and family carers of people with dementia
- Review of performance of current self- management provision and future need to inform future commissioning to improve the quality and effectiveness of services and avoid duplication
- Developing plans for service improvement, development and commissioning in Wandsworth homecare and care homes by reviewing and identify current gaps in provision and pathways with homecare and care homes in order to reduce and/or avoid admission to hospital through better homecare and care home provision and pathways
- Review of older people's liaison psychiatry provision within acute care
- Service implementation and launch of Specialist Clinical Dementia Lead/nurses team within primary care to enable people to live well for longer and within their own homes

- Evaluation of memory assessment service in 2015-2016.
- Mapping and redesigning End of Life care pathways for people with dementia
- Review delivery, performance and effectiveness of reconfigured Community Mental Health Teams for older people as detailed within revised service specification.

5.12 Mental Health CRG

- Review of Talking Therapies.
  The review of psychological therapies overseen by the MH CRG is seeking to achieve improvements in relation to the core contracted IAPT service provided by SWLSTG. The MH CRG has targeted a reduction of the waiting times between referral and assessment to 21 days; and from assessment to entering treatment to 28 days. Work towards the national coverage target of 15% of those identified with anxiety and/or depression is also identified. Alongside these a sustainment of the national target recovery rate of 50% by March 2015 is also targeted. A monitored Action Plan is in place in order to evidence an appropriate trajectory towards these targets by the end of 2014/15 with the key actions including improvements to access through improved web page and referral mechanisms; reduction in existing waiting lists and sustaining such reductions; reducing DNA's; improving GP relationships and liaison and developing access for BME communities. WCCG are also seeking to ensure that contribution to national IAPT figures are optimised through ensuring that appropriate input is made through the widest range of existing psychological therapies including those provided by Big White Wall, other third sector provision and practice based counsellors. Longer term WCCG are keen to ensure that commissioned IAPT services best continue to meet the prescribed national targets whilst provided a holistic service to meet needs which are increasingly complex.

The range of initiatives listed previously continues to constitute the MH CRG work programme and will continue to develop. These will be:

- BME representation in MH secondary care services
- Service User and Carer Experience
- Review of best practice for common mental health disorders in primary care.
- Wider transformational review of residential rehabilitation. This review will be in collaboration with WBC and SWLSTG and will include in-patient, supported houses and community support.
- MH Joint Commissioning Plan - Implementation of Action Plan.
- Older Adults Community provision – see Dementia CRG intentions.
- CAMHS – see YP CRG intentions
- Adult ADHD service – local pilot.
- Dual Diagnosis (MHLD) – implementation of review of provision.
- Dual Diagnosis (substance misuse) – input into re-tendered Substance Misuse contract.
- MH Tariff – go live 15/16. Continued work with cluster colleagues and SWLSTG to develop an appropriate cluster wide tariff.
- Choice in MH services (Cluster wide) – await guidance through cluster leads.
- Perinatal Services – implementation of proposals to re-shape current services to improve pathway and outreach potential.
- Development and mainstream of SUN project for people with personality disorders (Cluster wide)

- SWLSTG Transformation programme work in conjunction with Cluster (including community transformation; acute care pathways and CAMHS)
- Tier 4 and Estates Modernisation strategy consultation work (Cluster wide)
- Debt management and Mental Health – literature review produced.
- Suicide Prevention – Working group established and reporting progress to MH CRG
- Needs Assessment – completed and included in MH Joint Commissioning Strategy

5.13 Children's Services

The Children's CRG work plan is outlined below and work will continue on the following areas.

- Female Genital Mutilation
- CAMHS /PHSE
- Teenage Pregnancy
- Childhood Obesity
- Health Visiting / Health Improvement Plan
- School Nursing
- Community Paediatrics
- Immunisations
- Child Accidents
- SEN Reforms Sept 14
- Commissioning in Special Schools

In addition to the above work streams work will continue on the commissioning intentions outlined below.

- CAMHS Service Redesign to support the new Access Service by the development of clinical session by session outcome measures by 14/15
- Single Point of Access – Children with Disabilities. This will simplify the access to services for children with complex needs for parents and professionals. The pathway will need to be established.
- CABIN pilot may develop a new method for reducing admissions for children with minor infections by 2015. This may lead to more cost effective commissioning arrangements from April 2015
- Place 2 Be-Early intervention Counselling service for children and parents in Primary Schools. This service is jointly commissioned by the LA / CCG / Education and procurement will take place in 2015.
- NICE Compliance children with ASD / ADHD. CCG investment to ensure that the CAMHS, ADHD and ASD teams are NICE compliant. This work will be reviewed quarterly in the Community Paediatric Review Group.
- Increased Occupational Therapy resource to support children with Disabilities. OT services are under resourced to support this vulnerable group of children. This work will be reviewed quarterly in the Community Paediatric Review Group.
- The commissioning of Special Schools is currently being reviewed and it is expected that a report will be completed with key recommendations for commissioners in October 2014. This will inform commissioning arrangements in 2015.
- The implementation of the SEN reforms will lead to new commissioning arrangements for children with Disabilities. It is anticipated that to meet its

statutory responsibilities that the CCG will have to commission additional clinical resources in 2015/16 e.g. Designated Officer role.

5.14 Falls and Bone Health CRG

Community based Fracture Liaison Service

- Ensure a specialist osteoporosis role is part of the service, thus ensuring that the prescribing of denosumab can be provided within a community setting

Integrated service

- Integrated Falls Prevention, Management and Bone Health service specification developed to enable a fully integrated service to be jointly commissioned by the CCG and Council from 1st April 2015

The Falls and Bone Health CRG is now accountable to both the CCG and Council. As a result, further work is now being undertaken to improve pathways between health and social care as well as to review services which are commissioned separately by both organisations

5.15 Cardiovascular Disease CRG

To commission appropriate self-management programmes, which enable patients and their carers to feel empowered and supported to live as full a life as possible after diagnosis or an acute event.

- Work continues with St George's NHS Healthcare Trust to increase the number of patients accessing cardiac rehabilitation through the Continuing Cardiac Care service.

Work closely with the End of Life Care (EOLC) CRG to improve care for all those approaching the end of life

- Links are being developed between the CVD CRG and the End of Life Care (EOLC) CRG to improve care for all those approaching the end of life. Focus to date has been on patients with chronic heart failure.

Support primary care to provide good management of people with or at risk of CVD by commissioning.

- Work is on-going to develop a primary care based 24 Hour ECG diagnostic service;
- A review has been undertaken on anticoagulation service provision in Wandsworth with a view to determining future commissioning arrangements.

5.16 Wandsworth Self-Management Service (WSMS)

- The supporting self-management training for Healthcare Professional will take place in the format of a course. This is currently being finalised and will be ready to deliver by the end of September 2014 with the first course taking place in early October 2014.

- The condition specific training is being conducted in partnership with the workforce development team. The specifics are yet to be finalised but we expect delivery to commence in the coming months.

5.17 End of Life Care

The development of projects is underway with a view to delivery commencing early in 2015.

6. 2015/16 New Commissioning Intentions

6.1 West Wandsworth Locality

For 2015-16 West Wandsworth will continue with its focus on Mental Health, Cardiovascular Disease and Health Schools.

The locality will also look to focus on Sexual Health and Cancer, linking in with the Borough wide strategies that have been produced for these areas.

Engagement with patient and the public, and member practices will be ongoing as will engagement with the Queen Mary's Hospital Strategy Group.

6.2 Wandle Locality

For 2015-16 Wandle will continue with its focus on Obesity, Seldom Heard Groups and A+E attendances, Schools.

The locality will also look to focus on COPD and Diabetes, linking in with the Borough wide strategies that have been produced for these areas.

Engagement with patient and the public, and member practices will be ongoing and we will be looking to continue to provide our Advice and Community Referral Service.

6.3 Battersea Locality

There are a number of Project initiatives that Battersea Locality will be investigating the viability of to deliver in 2015/16. These project ideas are in the early stages and Battersea Locality are working closely with the Wandsworth Public Health team and involve the Locality Patient Consultative Group to test their viability.

6.4 Primary Care

In 2015/16 we will continue to monitor, review and develop the initiatives that launched in 2014/15 with a particular focus on the development of equal levels of service across General Practice, encouraging collaboration where appropriate, to ensure all patients across Wandsworth have access to a range of high quality primary care services locally.

In addition we will be seeking to improve links between primary care, social services and community services, to ensure that patients are placed at the centre of out of hospital services and are empowered and supported to remain healthy at home for as long as possible.

6.5 Community Adult Health Services (CAHS) redesign

Rapid Response Pathway (Phase 2 of pilot)

- Evaluation of Phase 1 of the pilot (as above) has scoped the need for the Rapid Response Carer service with LAS and local GP's. The CCG have put forward a proposal for further funding via the Better Care Fund (BCF) and if it is likely that the BCF board wishes to continue this service, a procurement process would need to be undertaken.

Health Education for South London (HESL) bid for scoping educational need for staff in nursing and residential homes in Wandsworth (Phase 2)

- Evaluation of Phase 1 of the pilot will be conducted by the Provider and CCG. Following evaluation, a business case will be submitted to outline the case for substantive posts.
- In April2015/2015 the CCG will be required to commence the procurement process for tendering out Community Services. It is envisaged that the tendering process should be concluded by April 2016/2017 and a new contract awarded to the successful bidder.

6.6 Cancer CRG

- Macmillan Physical Activity Programme for Patients with Cancer
- Best Practice Commissioning Pathway for Colorectal Cancer
- Provision of chemotherapy services with a view to deliver closer to home if appropriate
- Patient experience discovery interviews as part of the corporate social reasonability function

6.7 111 and OOH CRG (urgent care systems)

- NHS 111 and OOH procurement (with SPoC and UCC provision)
- Extension GP in-hours provision for St Georges UCC (from 25th November 2013 to 31st March 2015) – to be agreed
- Extension of 111 contract from 25th November 2013 for 12 months (renegotiated as block contract based on 65,000 calls)
- Review of Clapham Junction GP Led Health Centre contract with a view to extending hours.
- The development of Queen Mary's MIU as an urgent care centre, ensuring that it optimises the primary care and admission avoidance pathways for the Urgent Care Centre, and ensuring that the service delivers the best patient outcomes and patient experience.
- Winter pressures – To provide additional capacity within primary care setting during the busy autumn/winter period to ease pressure on General Practice and in appropriate attendance at accident and emergency. The additional capacity will be predominately outside of core hours with the facility for practices to utilise up to 50% of indicative budgets for late afternoon clinics for school age children.

6.8 Diabetes CRG

Diabetes - tier 3 community clinics

Diabetes CAHS and revision of existing service to introduce the tier 3 community clinics. Moving to an integrated model that will carry a "bundled" tariff based upon outcomes.

Redesign of existing pathway via the shift of patients from tier 4 to other tiers.

Self-Management

- To look to commission the delivery of the Expert Patients Programme through its recurrent budget, from April 2015 onwards.
- To offer a viable alternative to the Expert Patients Programme through a shorter patient course. Currently, the only patient self-management course the service offers is the EPP. Feedback has shown that patients would like a shorter alternative.
- To create a central signposting service that delivers beyond the existing model of course delivery.
- To help push the 'social prescribing agenda'

6.9 Respiratory CRG

This will depend on the outcome of the Asthma review project

6.10 Locality Stroke and Neuro Rehabilitation CRG

- Commission high quality community services for stroke patients; this will include information, advice and support services
- Development of services that support the NOF measurement of reporting an improvement in activity /lifestyle at six months post stroke
- Commissioning of a 6 month review services for people who have had a stroke
- Develop services to identify stroke patients within Primary Care
- To commission a range of engagement activities to ensure that local patients, carers and residents are taking part in discussions about the future development and provision of Stroke & Neuro Rehab services in Wandsworth.
- Additional capacity within the current Early Supported Discharge and Community Neuro Team will need to be commissioned as it has been identified that this service has seen a significant increase in the number of referrals made to this service.

6.11 Mental Health CRG

These can be cross referenced with on-going work programme and may lead to new intentions as the work streams develop:

- BME representation in MH secondary care services. Work programme for sub-group to focus on key areas under prevention/wellbeing; early intervention; assessment process and admission and discharge.
- Review of Talking Therapies. Evaluation of improvement actions to meet National KPIs.
- Service User and Carer experience – developed in response to on-going work programme.
- Review of best practice for common mental health disorders in primary care.
- Wider transformational review of residential rehabilitation. This review will be in collaboration with WBC and SWLSTG and will include in-patient, supported houses and community support.
- Older Adults Community provision – see Dementia CRG intentions.
- CAMHS – see YP CRG intentions
- Adult ADHD service – local pilot.
- Dual Diagnosis (MHLD) – implementation of review of provision.

- Dual Diagnosis (substance misuse) – input into re-tendered Substance Misuse contract.
- MH Tariff – go live 15/16. Continued work with cluster colleagues and SWLSTG to develop an appropriate cluster wide tariff.
- Choice in MH services (Cluster wide) – await guidance through cluster leads.
- Perinatal Services – implementation of proposals to re-shape current services to improve pathway and outreach potential.
- Development and mainstream of SUN project for people with personality disorders (Cluster wide)
- SWLSTG Transformation programme work in conjunction with Cluster (including community transformation; acute care pathways and CAMHS)
- Tier 4 and Estates Modernisation strategy consultation work (Cluster wide)
- Debt management and Mental Health – literature review produced.
- Suicide Prevention – Working group established and reporting progress to MH CRG
- Needs Assessment – completed and included in MH Joint Commissioning Strategy

MH Cluster intentions include (to be confirmed).

- Continue to champion “parity of esteem”
- Achievement of IAPT national targets
- Develop common whole-system CQUIN
- Develop a physical health pathway which supports people with Mental Health including Dementia
- Review models for psychiatric liaison services and develop a model for SW London
- Implement Mental Health Tariff
- Develop better outcome based commissioning and contracting.
- Early onset/Young Adult Onset Dementia - Providers to work with Commissioners to develop a service model that meets the specific needs of these patients, across the Collaborative SW London Commissioning model.

6.12 Children’s CRG

- In partnership with the Local Authority the CCG are currently undertaking a review of commissioning for children in Special Schools, the outcome of which may identify new commissioning options for 2015/16. The key outcome of the review and resultant recommendations are subject to agreement by the CCG/LA but are likely to include:

    - To integrate therapy teams within the school’s management team and for the school to undertake direct commissioning of this service from an agreed framework (to a service specification agreed by the CCG/LA). Initially piloting this in one school, with a view to eventual roll out across all schools by 2017.
    - As host Commissioner the CCG intends to recharge neighbouring CCGs where health services are provided to children within Wandsworth Special Schools who are registered with a GP outside of Wandsworth.
    - Practical training for parents and school staff to empower parents and staff to empower them to support the children by increasing key skills and knowledge about how children with social communication needs develop their skills and the challenges they face.

- The outcome of the current review of Community Children Services may identify new commissioning arrangements in Children’s community services for 2015/16.
- The outcome of the current review of the Health Needs of Children Looked After may identify new commissioning arrangements for 2015 /16.

- The outcome of the CABIN pilot may lead to a new method for reducing admissions for children with minor infections and revised commissioning arrangements from April 2015
- The Children's Phlebotomy Service may move to a tariff arrangement in 2015 /16.
- SEN reforms September 2014 – Children with Disabilities. The implementation of this legislation in Wandsworth places additional responsibilities on the CCG and may lead to the commissioning of new posts and services.
- Child Mortality- Wandsworth is developing a multi-agency programme and strategy to reduce child deaths as a result of Asthma. This programme is being developed and reviewed at the Community Paediatric review meeting.
- South West London Children's Collaborative commissioning is developing a 5 year strategy for children services. The collaborative will be looking at the following areas
    - CAMHS
    - Under Five Year Olds
    - Children with Disabilities
    - Paediatric Admissions – Acute
- The collaborative may provide opportunities for joint commissioning arrangements to be developed across the region in the areas specified above.
- Health Visiting Boundary changes may also lead to new commissioning arrangements as the service moves from GP registration to borough boundaries.

6.13 Falls and Bone Health CRG

Wandsworth CCG and Borough Council will jointly commission integrated falls prevention, management and bone health services. The service will encompass the following elements covering both acute and community service:

- To case-find patients who have had fragility fractures in the past or are at risk of osteoporotic fractures; investigate bone density; initiate drug and other treatments to reduce the risk of a future break, as well as monitor and maintain medication adherence; ensure appropriate patients are offered a bone health programme offering education, assessment and exercise classes.
- To ensure patients at risk of a fall and/or are concerned about falling, receive a falls risk assessment and includes a care plan to address reversible risk factors; to offer appropriate patients an evidence based falls prevention education and exercise programme.

The CCG will also commission the following services:

- **Patient Identification -** Patients who have sustained a fall in the past year and/or are concerned about falling in the future and refer into falls prevention services where appropriate as well as patients who have sustained a fragility fracture and/or are at risk of developing a bone health condition and refer into diagnostic services and/or evidence based bone health exercise programmes where appropriate
- **A Handyperson Service** - To ensure older people living in Wandsworth remain safe and secure in their home environment and are able to maintain independent living for as long as possible.
- **A Single Point of Contact Service** - Available to frontline health and social services professionals as well as local residents to support vulnerable individuals at risk of falls to signpost and refer on to falls prevention and housing services;
- **Appropriate diagnostic services** (e.g. DEXA scanning facilities) for Wandsworth patients

6.14 Cardiovascular Disease CRG

To engage patients, carers and the public in service developments and the wider implementation of the Cardiovascular Disease Outcomes Strategy

- **Manage CVD as a single family of diseases -** to develop a standardised CVD EMIS assessment template. This template will list all the factors that a healthcare professional should consider when conducting a CVD assessment. This template will ensure that there is a consistent approach to assessing CVD risk across all Wandsworth GP practices.

- **Improve prevention and risk management -** To support Wandsworth Borough Council through the CRG and Localities to encourage the local population to adopt healthier lifestyles. A specific focus will be on NHS Health Checks, Smoking and Exercise Provision

- **Improving and enhancing case-finding in primary care**
    - To identify patients at risk Atrial Fibrillation (AF) to ensure that patients are managed appropriately;
    - To commission high quality diagnostic services based in primary care – focus will be on improving the primary care hypertension pathway including the introduction of Telehealth, reviewing and re-commissioning the 12lead ECG service and developing a 24 Hour ECG primary care diagnostic service.
    - To commission bespoke training courses to support primary care health professionals in providing investigations to support evidence-based clinical care in line with guidance.

- **Better identification of very high risk families/individuals-** To develop clear prescribing and local guidelines for primary care to improve the identification of individuals and families at very high risk of Familial Hypercholesterolemia (FH).

- **Better early management and secondary prevention in the community -** Lipids - To implement the revised NICE clinical guidelines on lipid modification (published July 2014) focusing on CVD risk assessment and the modification of blood lipids for the primary and secondary prevention of CVD
- **Improve acute care**
    - Heart Failure - To commission a high quality chronic heart failure pathway by ensuring that patients receive the right treatment, at the right time by the right staff
    - Arrhythmias and Anticoagulation - Design and implementation of new arrhythmia and anticoagulation pathways ensuring that patients receive the right treatment, at the right time by the right staff (projects are currently under review by the CVD CRG but will include medicines management i.e. NOACs v warfarin
- **Improve care for patients living with CVD**
    - Continuing Cardiac Care - To improve access to appropriate rehabilitation to reduce the risk of another event and self-management programmes enabling them to feel empowered and supported to live as full a life as possible after diagnosis or an acute event;
    - IAPT for patients with long term conditions – To improve access to psychological therapies for patients living with coronary heart disease and to scope provision for patients living with arrhythmias;

- **Improve end of life care for patients with CVD -** To work closely with the End of Life Care (EOLC) CRG to improve end of life care for patients with CVD in Wandsworth

6.15 Wandsworth Self-Management Service (WSMS)

- To offer a viable alternative to the Expert Patients Programme through a shorter patient course. Currently, the only patient self-management course the service offers is the EPP. Feedback has shown that patients would like a shorter alternative.
- To create a central signposting service that delivers beyond the existing model of course delivery.
- To help push the 'social prescribing agenda'

6.16 End of Life Care

It is anticipated that the pilot will run from January 2015 until January 2017. Learning from both the development and delivery of the pilot will inform decisions around the future commissioning of similar initiatives.

6.17 Other Services

Tier 3- 4 Bariatric

Wandsworth CCG and Wandsworth Council will jointly procure the Tier 2, Tier 3 and Tier 4 adult weight management services. The joint procurement will support delivery of the Healthy Weight Strategy and ensure better alignment of Wandsworth adult weight management services.

AQP All body parts physiotherapy

The Wandsworth CCG AQP All Body Parts Physiotherapy service will go live on 1 October 2015 following procurement.

MSK

Commissioning of the MSK service(s) in 2015/16 will seek to provide a community-based MSK service. The approach will include making practical improvements to the existing services (Central booking service, GP direct access physiotherapy, Musculo skeletal Clinical Assessment & Treatment Service, Pain Management service, dedicated joint injection clinic) to improve the patient pathway. The service is due to be implemented in July 2015, following procurement.

Dermatology

Commissioning of the Intermediate Level 3 Dermatology service in 2015/16 will seek to provide services as near to patients as clinically appropriate and to adopt a stepped care model which is integrated into primary care. This means that patients can access services of high quality quickly and be seen by most appropriately skilled health professional to meet their needs. The service is due to be implemented in July 2015, following procurement.

Ophthalmology

This service will provide a whole community ophthalmology model of care which is more integrated, fit for purpose and sustainable to cope with the growing demand for eye care. The service will improve accessibility, efficiency and provide care closer to home and ensure more effective use of skillbase within primary care. The service is due to be implemented in July 2015, following procurement.

7. Appendices

7.1 Patient Involvement/Engagement

West Wandsworth

The West Wandsworth Patient Consultative Group meets on a monthly basis and is updated on the progress of the locality priorities, and the proposed new areas have been discussed with them.

Both the Mindfulness courses and the sleep disorders courses were suggestions that came from the Patient Group, and are now being implemented.

Wandle Locality

The Wandle Patient Consultative Group (PCG) is attended by representatives from most practice patient groups. Active recruitment is ongoing to encourage those practices that do not send representatives to do so. The group meets once every six weeks and is chaired by elected patient chair Marion Endicott.

The group is invited to contribute to commissioning needs assessments, strategies and CCG positions during early drafting and CGG and Public Health staff frequently attend to present CCG work to this group. The group also runs focused workshops within their meetings, allowing them to directly influence strategies and service redesign. Recent examples include Community Services Redesign, Ophthalmology and 111.

Battersea Locality

Battersea Locality Commissioning Group (BLCG) has also worked with specific patient, public and carer groups to ensure focused patient involvement where specific projects require additional input and to develop the understanding of the group about commissioning and healthcare provision in the area.

The Battersea Patient Consultative Group have been involved in each step of the development of the Locality Initiatives and the project lead has attended Wandsworth Youth Health Jury meetings to discuss and listen to the advice from it's members on the Condoms, Chlamydia and HIV project.

To ensure strong links, continuity and transparency between the Battersea PCG and the Locality Members Forums the locality have agreed to continue to have the same Lay Representative as Chair for both groups. The Chair acts as a conduit between each respective group and has been instrumental in developing joined up, high quality, clinically led patient care that has driven the agenda for all commissioning decisions in Battersea. BLCG has developed into a strong cohesive decision making group with a depth of experience and knowledge around commissioning healthcare. Having a Lay Chair, the Battersea Members Forum ensures the patient voice is at the forefront of all decisions in the locality. In addition to this, the Members invite two further patient representatives to all Members Forum meetings.

The Chairs from the three locality patient groups meet on a regular basis with the locality managers. It was agreed that a joint event should be held to bring the three locality patient groups together. The event was held in February 2014. An overview of each locality was followed by group work focusing on what makes a good patient group; what works well in practice and locality patient groups and what could be improved. All those who attended gave positive feedback and it is hoped another joint locality patient group will be held event later this year.

Primary Care

Patients have been involved in the development of all initiatives outlined within our commissioning intentions for primary care. This has taken place through a variety of different mediums including patient representation on Clinical Reference Groups, workshops carried out with Locality Patient Groups and other feedback techniques including surveys and interviews.

Community Adult Health Services (CAHS) Redesign

The CCG have been working with key stakeholders including the Provider, Public Health, Health-Watch, Social Services, Finnamore and the Patient & Public involvement team to establish an effective method for analysing patient satisfaction, focusing on the patient journey through the implementation of the redesigned Community Adult Health Service (CAHS).

It was agreed by the above mentioned stakeholders that the CCG would conduct x20 face to face patient interviews per quarter. The CCG would work with the Provider in sourcing patients and carers who would be willing to take part in the interviews. The interviews would be recorded on a digital recorder and transcribed with the patients' consent. All questions in the first quarter would be kept open-ended, asking the patients and carers about their experiences of the healthcare they currently receive and any positives and negatives they have experienced.

Once the first quarter of interviews has been completed, the transcripts would be analysed by a Review Group (consisting of Public Health, Provider, Social Services, HealthWatch, Finnamore and the CCG). The Review Group would determine the emerging themes arising from the interviews (e.g. Patient care, communication, hospital transport) and this will help to shape the interview questions and approach moving forward. It is envisaged that the feedback emerging from the patient and carer interviews will be used to inform the Providers' internal Task and Finish groups which will in turn help to shape the implementation of the re-designed service.

The CCG have also worked to establish a patient 'Critical Friends' group, consisting of patients and carers. The Critical Friends group will provide a forum for patients and carers to have a voice and share their experiences of the healthcare they receive, be it in a home or hospital setting.

The CCG contacted patients and carers via a mail-out and have received responses from 18 interested individuals so far. The CCG ran its' first workshop for Critical friends on the 31st July and talked to patients and carers about the vision of the re-design. Individuals were asked for their opinions on how they would like to see the work-shops operating in the future

and their views on the healthcare services they receive. Patients and carers identified the gaps in current services and the need for improving communication and awareness of services in the community available to patients.

The workshops will run on an eight-weekly basis and will be chaired by the CCG, however it is anticipated that the workshops in the future will also pull in the Provider services as and when appropriate as guest speakers, which will help to inform patients and carers of the work being undertaken on the ground as well as giving an opportunity for the Provider to hear how their hard work is being received by patients and carers.

The feedback arising from the workshops will also be fed back to the Providers' internal Task and Finish groups, helping to shape the implementation of the re-design.

Cancer CRG

- Patients are represented on Cancer CRG where commissioning services are discussed
- Get to Know Cancer Event – opportunity to discuss services commissioned Wandsworth

111 and OOH CRG (urgent care systems)

Patient representation on 111 and OoH CQRG.

(not done within the timescales required)

Diabetes CRG

There are 3 patient representatives on the membership of the CRG who are also members of the Wandsworth Diabetes Patient Group. These representatives are able to comment and input into all levels of planning and also provide a link to wider participation from the patient group

Respiratory CRG

As part of the recommendations within the Asthma review there will be an opportunity to engage patients in the development of any new materials or programmes that are developed.

Locality Stroke and Neuro Rehabilitation CRG

As this is a newly formed group we have yet to establish a patient representation. However links have been made with Connect a charity organisation and as such the opportunity now exists to regularly engage and discuss service development with their Steering group of Wandsworth patients/service users.

Dementia CRG

Intentions informed by the national dementia strategy and other relevant policies.

Intentions informed by extensive consultation on the dementia pathway focusing on the front end of the pathway, which includes Memory Assessment, post diagnostic clinical support (leading to the securing of investment for the specialist dementia nurse team), as well as the mapping of dementia training , which saw a number of engagement events held and tools utilised to ascertain current provision and identify gaps to inform a training delivery plan..

Users and carers views represented by core CRG members from both the Carers' centre and Alzheimer's Society.

Mental Health CRG

1. Engagement on development of Mental Health Joint Commissioning Plan
2. Service User and Carer membership of MH CRG agreeing work programme and priorities
3. Service User reference groups and MH IG feed into work programme and specific actions around Service User and Carer experience.

For more information please refer to Engagement and Participation activity within Duty to Report.

Children's Services

Local Youth Health Jury have completed a review of the local CAMHS service and named the new Access service commissioned by the CCG

Falls and Bone Health CRG

- Patient representative in attendance at the Falls and Bone Health Clinical Reference Group;
- Patient and Carer event provided feedback on existing services as well suggestions on how services could be improved. This has been fed into the commissioning intentions.

Cardiovascular Disease CRG

- Patient representative in attendance at the Cardiovascular Disease Clinical Reference Group;

Wandsworth Self-Management Service (WSMS)

This is currently, primarily being achieved through the newly setup critical friends group and the bi-monthly tutor meetings. The critical friends group feedback on the service and identify areas that they feel need to improve. The tutor meeting is used to gauge the quality of the existing courses and discuss any operational and marketing issues.

End of Life Care

The need for improved co-ordination of care and communication across service providers was discussed at the EOLC Community Engagement event held in April 2013. These discussions informed the development of the pilot project;

- The EOLC CRG has a PPI representative who sits on the Pilot Project Board and associated pathway/task groups. Her views and experiences are encouraged, listened to and incorporated in to the planning and development process;

- Patient and carer experience will be an important element of the pilot evaluation process.

Service Area Summary

Service area	Mapping/ Scoping/ Review	Revised Spec	Revised Tariff	Review Revised Pathway	Procurement
CAHS	X	X	obc framework	Frailty IV Pathway Reablement	2016/17
Cancer				Streamline 2 C referral pathway	
Diabetes		Tiered model and structured self mgt education	Tiered model and structured self mgt education	Tiered model	
COPD				X	
Neuro Rehab/ Stroke	X			X	
Dementia					? handy person
Falls	X				
CVD	X	X Assessment and Care Planning			
Primary Care	Planning all Care Together Contract Diagnostic Contracts				
Mental Health	Talking therapies Rehab services (may lead to procuremen t) BME representati on sub-group work, may lead to new specs or procuremen t	Perinatal (alongside pathway)	Yes MH tariff	Perinatal	
Children	Community Children's Services Commissioni ng in Special Schools	Community Services Therapies Special School Nursing	Paediatric Phlebotomy		Place to be

	Health Needs Children Looked After South West London Commissioning Collaborative will review the following services CAMHS Tier 4 / Tier 1/ Children With Disabilities /Under Five Year Olds Paediatric Admissions SEN Reforms review of the statutory requirements for the CCG	Community Services			
Self Management				X	
Falls/Bone Health					SPC Handy person
Other					Community Dermatology & Ophthalmology MICAS AQP Physio – all body parts Tier 3/4 Bariatric Service