Corby and Nene CCGs Commissioning Intentions 2018/19

Final Version

ALL

9/29/2017

Contents

1. Introduction

1.1. NHS Corby Clinical Commissioning Group (CCG) and NHS Nene CCG are clinically led commissioning organisations authorised by the Government to plan, buy and monitor healthcare services for approximately 754,000 people living in the county of Northamptonshire. We have statutory accountability for defined geographical areas within the county, and we are supported in our actions by our membership (local GP surgeries).

1.2. Each year as part of the planning cycle we are required to issue commissioning intentions to each of our providers. This document forms that deliverable.

2. Approach

2.1. This year we have changed our approach to joint planning and integrated commissioning delivery. As separate statutory bodies we are speaking with one voice to all providers through a single document. We have worked with our governing body clinical representatives, membership and clinical colleagues responsible for oversight of the Northamptonshire Sustainability and Transformation Plan (STP) to develop this document. To support us in this joint approach we are using a methodology the system is familiar with; the 'settings of care' approach that we have used to develop the Urgent and Emergency Care strategy in 2017/18.

2.2. In order to support this approach, and to draw on the wealth of local knowledge and public health evaluation of variation in population outcomes, the Commissioning Intentions have started with the patient pathway at their centre. These pathways have been tracked across the settings of care this allows the CCGs to clearly set out the expected activities by setting and for us all to start to match those to the resources and activities we actually have. By this approach we will demonstrate the changes and improvements required in each setting of care to improve the overall management of health conditions, including:

- Prevention and Self-management
- Primary Care
- Enhanced Primary and Community Care
- Intermediate Care
- Acute Care.

2.3. As part of developing this approach, the views of our patient participations groups (Patient Congress- NHS Nene and PPEA – NHS Corby) have been sought in some detail. They are aware that we need to signal some changes to the system and its current configuration. Through these discussions we have debated the approach (settings of care, clinical drivers

and patient pathways driving required change) and they wholehearted endorse that approach. We have also indicated that to get the system back into some form of financial as well as clinical balance there are some things that we need to do faster, some things we need to do slower and some things we need to stop entirely. Our patient representatives have asked that we use clinical quality drivers and patient experience and include them in those conversations, but again have entirely endorsed that approach.

2.4. The Commissioning Intentions 2018/19 are issued during a time of significant change in the health and care system. The development of the STP for Northamptonshire is intended to provide a framework for enhanced partnership working that ensures that value is driven across the local health and care economy. This approach, putting clinical and quality drivers, patients pathways and transparency about activity in each setting, at the heart of what we do should ensure that organisational barriers do not prevent the best possible outcomes for the population delivered within the resources available within the county (and beyond). The Commissioning Intentions are both drawn from and should shape the STP going forward. The current Commissioning Intentions should form a basis for the System Intentions for Northamptonshire.

3. Process

3.1. The same document will be received by each provider we commission from and is framed as follows:

a) A simple narrative is provided that describes the context and landscape we are working in

b) Individual health interventions and patients journeys by pathway are mapped across settings in which our population access their care in

c) We have introduced self-care and prevention into the interventions we are describing to start to improve strategic visibility to all providers of non-medical services available to our population

d) An individual contract coding and counting letter that is unique to each provider will accompany the document.

3.2. This approach has been evidenced in other systems to deliver the following benefits:

- Clarity between providers on interventions in other settings to support STP and system developments
- Clarity between clinicians on handover points on patient journeys to reduce professional duplication of support
- Clarity on gaps in the provision of support services - although we have duplication of delivery for people in some areas causing complexity and confusion, gaps in service needs remain in other areas

- ‘Left shift’ in activity to lower cost settings closer to patients own homes
- Reduction in duplication in clinical pathways which leads to clearer QIPP and CIP opportunity for the health system as a whole.

4. Planning

4.1. The drivers and documents we have used to develop the Commissioning Intentions, include:

4.1.1. The CCGs issued a joint Operating Plan in 2016/17 which set out the commissioning intentions for a two year period between 2017-19. Therefore this year’s Commissioning Intentions set out an updated position set against current contracted services and plans.

4.1.2. The Northamptonshire STP is moving into its third year of operation and is refining proposals to move towards enhanced partnership working that delivers improved outcomes as well as excellence in service provision. This requires co-ordinated development of commissioned services across a range of care settings, to ensure the greatest opportunity to impact on health and wellbeing.

4.1.3. The NHS Operating Plan, developed nationally by NHS England (NHSE) and NHS Improvement (NHSI), provides the mandate under which NHS commissioning bodies must function with a focus on safety, quality and cost efficient care across services and within a range of priority areas.

4.1.4. The RightCare map of opportunities for Corby and Nene and the Menu of Opportunities developed to support planning and delivery across pathways.

4.1.5. The NHSE Five Year Forward View and Next Steps documents including the recent Integrated Urgent Care specification.

4.1.6. The GPFV – in addition to the commissioner responsibilities identified through this planning document, primary care improvements have become a mandated delivery within the STP

4.1.7. The quality challenge as set out in the shared commitment to quality from the National Quality Board published in December 2016.

4.2. The engagement of our public and patients in the design of commissioned solutions is essential and creates the real momentum in service and system redesign. The individual and their family must be placed at the heart of redesign processes, and this will be maintained and in many areas enhanced.

5. Prioritisation

5.1. The Commissioning Intentions reflect a journey that our system, including our patients and populations, has embarked on over recent years. Many of the intentions included in the document will be familiar to us all. However, it should be noted that some things described document outline interventions that reflect success in other systems and include aspects of best practice we have not yet been able to address. We do not expect that all intentions will be delivered in a single year, but will impact beyond 2018/19.

5.2. We will follow a prioritisation process with our clinical stakeholders including the STP clinical group, in October 2017. This will ensure that as we move our commissioning intentions into our operating plan refresh and this year's quality and finance plans, clinical priorities and drivers for change remain at the heart of what we do.

6. Pathway Changes

6.1. This document pulls together the key themes across our care pathways and sets out key changes proposed to:

- How services are commissioned and provided
- Where services are commissioned and provided to ensure we modernise our system
- How providers can work together to deliver complete pathways that match programme budget drivers and opportunities identified through clinical evidence and Right care
- How we access our care
- Support to our clinical staff and health and care professionals
- Our commitment to improving the overall health of the population

6.2. Our commissioning intentions are set within the context of unprecedented sustained and significant financial challenge across health and social care requiring new models of care, greater collaboration and joint working, and a focus on prevention and self-care.

6.3. The move away from a traditional commissioner/provider split will reduce transactional costs, and the move to an enhanced partnership across health and care providers must ensure that best value opportunities are realised. This cannot reduce a focus on safety and quality across services and organisations and the necessity to drive continuous improvement across care pathways.

7. Finance

7.1. Commissioners and Providers in Northamptonshire face a significant and collective challenge to achieving financial balance across the health system. In 2017/18, Corby CCG is delivering a QIPP programme of £3.6m and Nene CCG a QIPP programme of £36.6m. Financial planning for 2018/19 is in progress. The CCGs will begin 2018/19 with a total saving (QIPP) requirement which is greater than in recent years, due to financial pressures and non-recurrent savings needing to be made recurrent. Current plans show a requirement for Nene CCG of £39m (4.6%). Corby's requirement is currently being assessed.

We are aware that our providers and partners also continue to face significant financial challenges, and there will therefore need to be a focus on the health and social care system as a whole delivering the right quality of care at a lower cost to ensure the continued financial viability and long-term sustainability of all the organisations in the Northamptonshire system.

7.2. The STP will be a key vehicle for addressing the challenge and developing the range of initiatives we can share with providers to meet respective but linked QIPP and CIP targets, whilst taking account of the need to deliver the improvements and developments set out in this document.

7.3. Activity levels for Urgent Care, Elective care and GP referrals have risen markedly in recent years, and the growth in 2017/18 is following that trend. Increasing activity levels places increasing demand on the limited resources available. The Northamptonshire Health system needs to return to, and remain within, a sustainable service and financial framework. The commissioning intentions will drive the operating plan that must meet sustainability requirements in order to move towards that goal.

7.4. Delivering the QIPP programme means the CCG will want to ensure that commissioned services deliver best value, and are affordable within available resources. The planning and contracting timetable will be agreed in order to implement a pragmatic means of achieving contract sign off by the due date, whilst dealing with all the relevant technicalities.

7.5. We will identify the resource implications of meeting all national and locally agreed planning requirements relating to the key priorities within an overall cost envelope agreed with our providers through the contracting process.

7.6. This process will be informed by the latest available tools and guidance including:-

- RightCare
- Demand Management Good Practice Guide
- NICE Guidance on delayed transfers of care.

8. Contracting Approach

As two-year contracts were signed for 2017-19, we will be looking this year to agree contract variations, as there a number of key developments and updates which are required and which we will need to work with the providers to deliver. Activity and financial assumptions will require updating and will be varied into the contract through the usual variation process, following the terms set down within the national contract. In addition, commissioning changes will need to be reflected and contracts updated for the new ways of working required for delivery.

More importantly, the local NHS needs to continue its journey to deliver an operational STP, and the contract remains a key lever of this.

Contracting priorities for 2018-19 are:

i) **Constitutional Standards**
The Northamptonshire system needs to deliver in full the standards as set down within the NHS Constitution, achieving both recovery and sustainability in areas of pressure, these include (but are not restricted to):

- A&E
- 62 day cancer waits
- RTT

ii) **Financial Sustainability**
The NHS continues to face its most significant challenge for a generation, and the reduction of cost and improvements in efficiency are critical to delivery of the services required. Services need to be provided on a right time, right place basis, and movements between contracts and/or new contracting models which assist this will be required. Through the use of risk/gain shares, incentives for outcomes and prime provider/whole system working models, a reduction in cost and a gain in efficiency will be driven through.

iii) **System Transformation**
Hand in hand with financial sustainability, the need for system transformation is paramount. The contracting approach and the commissioning that underpins it should encourage the process and behavioural changes required to deliver transformation.

9. Quality at the Heart of Commissioning

9.1. The people of Northamptonshire deserve to enjoy the best possible health and wellbeing, and receive quality care when they need it. We believe in everyone getting the right care, in the right place, at the right time. Quality should be central to everything we do, from planning and commissioning care; to the way we work with services to drive improvement and innovation.

9.2. The local challenges include:

- Lifestyle and wellbeing issues, which drive people into the health system particularly due to respiratory conditions, circulation issues, cancer and mental health as identified through RightCare
- The need to ensure that people are enabled to access the right health services in the most appropriate way
- Pressure and lack of resource deployed in and services delivered in out-of-hospital settings means that people end up in hospital based services by default (right shift)
- The need to ensure sustainability of General Practice and primary care services
- The need to ensure that acute hospitals services are supported, transformed and optimised to best serve the needs of our population
- Workforce shortages across the sectors which drive cost and hamper the ability to provide high quality services
- The need to improve integration of services across the system to improve efficiency and reduce duplication
- The need to ensure the system meets national quality standard including Cancer, and NICE guidelines and addresses CQC issues raised locally.

10. A Focus on Variation

10.1. Benchmarking variation is complex and, as the RightCare programme sets out, is the start and not the end of the design process. A variation in costs in one part of the system, may in fact be delivering a better set of outcomes for patients or reduced costs elsewhere. However, Northamptonshire have placed the RightCare methodology at the heart of planning and therefore the key areas for focus are as set out below. These care pathways are critical for the county as we drive towards improvements in outcomes for our population and sustainability for the system:

Nene & Corby CCG's

£'000	Electives	Non Elective	Prescribing	Grand Total
Cancer	-	1,133	296	1,429
Circulation	2,654	3,796	777	7,227
Endocrine	736	1,299	2,164	4,199
Gastrointestinal	978	2,264	781	4,023
Genitourinary	663	3,544	106	4,313
Mental Health	-	-	1,219	1,219
Muskuloskeletal	4,472	364	454	5,290
Neurological	2,253	3,752	1,237	7,242
Respiratory	568	5,553	1,223	7,344
Trauma & Injuries	-	2,332	41	2,373
Grand Total	12,324	24,037	8,298	44,659

11. Settings of Care

Although we are offering our commissioning intentions in respect to settings of care, there are some themes that have such a profound impact on our system that they need to be explained in more detail. We have seen significant activity growth in the Urgent and Emergency Care sector and have increased our investments in this area. However, it remains a challenge for us all to see sustained improvements in the Urgent Care experience for our population.

There are some aspects that we have ambitions to improve this year. These include clarifying the balance between Emergency care, Non Elective spells and what Elective options we need to offer to better plan for our population. We need to make progress on moving toward the ambulatory and emergency medicine delivery our population deserve in both pathway terms but also how we record the information to support commissioning developments. We currently do not use the best practice codes encompassed in the directory of ambulatory and emergency medicine, using zero day Length of Stay to count all activity. We will work through the detail of how this may be having a detrimental impact on activity, costs and total trust incomes through the contracting process this year.

A focus on Urgent Care:

11.1 Investments in this area have grown over a time of sustained pressure in the Urgent Care System and have been applied in response to tactical issues that the system has faced. Services have been layered over other services, and a wholesale consideration of the urgent pathways and their relative balance with elective services has not occurred.

11.2 This has delivered some improvements in 4 hour transit time in the Urgent system, but has not delivered a sustained improvement as new beds or a new service has been rolled out, rapidly followed by a deterioration in performance that has seemed inexplicable. This has occurred as the system has adjusted to its new baseline and without a fundamental change in approach.

11.3 This is a multi-factorial issue, which has been compounded by multiple escalation processes. National programmes of improvement have been followed, but they have been potentially layered over a system that has needed a more fundamental reset of resources.

11.4 Closer analysis of that resource has shown that we spend more in the Urgent Care system and have lost some focus on the elective or fast scheduled interventions that would prevent the use of urgent care systems for all but emergencies. Our current acute contract activity split is approximately 67% non-elective to 33% elective. We now need to be clear about what we can deliver in elective or scheduled care to support improved outcomes and the role this plays in supporting urgent care needs

How we will deliver across care settings?

11.5 Prevention/Self Care:

This area of work is central to how we will change the way the people are supported and support themselves it includes:

- Pharmacy and minor ailment support to people who become ill on the day
- Rehabilitation support for cardiac and respiratory issues
- More active management will take place in respect of:
    - Breathing Space Community COPD clinic
    - Acute care – KGH, NGH
    - Federations and super-practice
    - Rocket/Restart
    - Pulmonary rehabilitation

11.6 Primary Care:

Primary care will be a major contributor to the delivery of the ambition set out in these commissioning intentions:

- We will continue to facilitate extended opening; 8-8 and slots throughout the day for on-the-day booking, as people and particularly children become ill throughout the day. This will reduce the challenge in getting appointments at that point in time leading to inappropriate use of Urgent services when people have primary care needs.:
- We will complete the review of near patient testing we have already started and look at services that are related to this like anticoagulation and phlebotomy to ensure adequate community capacity for these services is commissioned in accordance with the evidence base
- We will continue to utilise the GP Forward View Transformation investment to work with primary care homes to support local practices to work together to provide primary care services

11.7 Extended Primary care (Primary Care Home):

We will manage our non-elective demand through effective Multi-Disciplinary-Team management for people with Long Term Conditions, and minor injury service support. This will be transacted through primary care homes and will include the following:

- Support for further development and reconfiguration of priority community services around primary care homes (specifically physiotherapy, community nursing and mental health support)
- Identifying and promoting elective services within primary care homes that are either underutilised currently or need additional capacity to support primary care home needs.
- Continuing to support practice clusters and their extended family to innovate in the use of technology to share information and process across services
- Working with all providers to actively support the coming together and development of multidisciplinary extended primary care family teams in our primary care homes
- Extending work done in 17/18 on in hours access at scale to establish a sustainable approach to provision of extended hours in primary care as part of the GP Forward View that utilises the extended primary care team
- Continuing engagement with the public about where the gaps are today and what their priorities might be for joined up services in primary care
- Delivering the demand management plan developed as part of delivering sustainable elective care
- Ensuring training and enhanced support is available to care homes – both nursing and residential – alongside Local Authority partners, so that people can be supported safely in their place of residence.

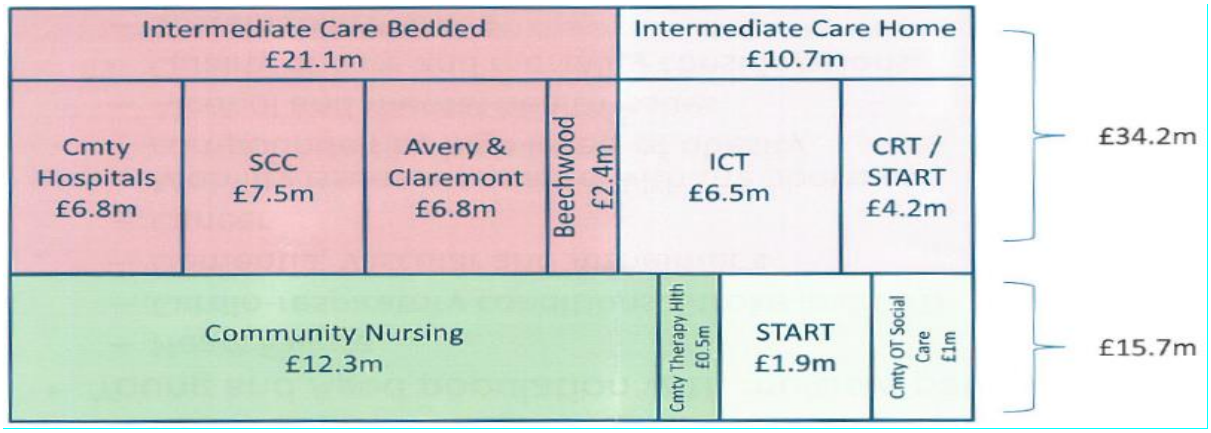
11.8 Intermediate services:

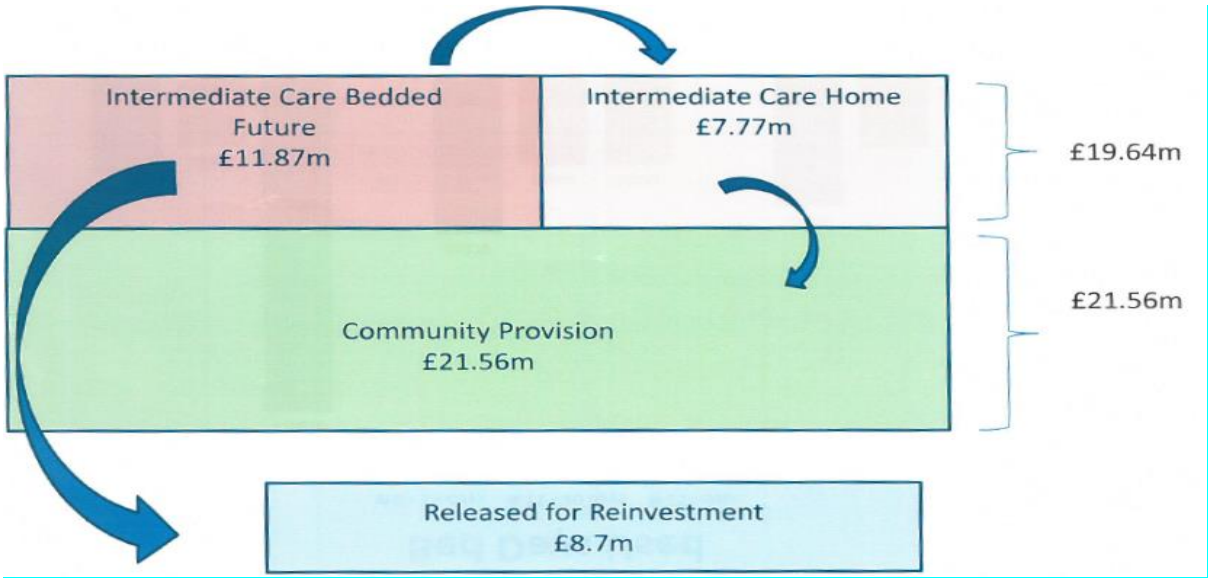
This transformation programme represents a central part of both the CCGs' Commissioning Intentions and the STP for Northamptonshire.

11.8.1 This element of the commissioning plan represents a new period of engagement for the CCG and the local health and care system into new models of supporting people to stay well and to maximise independence within the home and community.

11.8.2 Intermediate Care services have been under review for a number of years and have provided a significant focus for programmes such as Healthier Northamptonshire and the Better Care Fund. The system has assumed a lack of capacity in intermediate care services which has been a significant driver of urgent care challenges and hospital discharge performance. Initiated through the Better Care Fund and developed as part of the STP, it is now possible to demonstrate that Northamptonshire has an imbalance in interventions that means that resources respond post crisis, rather than having the capacity to prevent or respond swiftly to that crisis.

11.9 The current profile of investment in community services is shown below, with a high level of investment in bedded and post hospital rehabilitation:





11.10 The model varies significantly from other health and care communities where community nursing and social care community services have a greater proportion of the investment to manage crisis without hospital intervention and to support people home after brief hospital interventions.

Therefore in 2018/19 the CCGs will:

- Engage with public and clinicians to design new opportunities to deliver care close to home, maximising the use of resources to ensure that re-ablement and rehabilitation meets people's needs and minimises unnecessary time in an acute hospital bed
- Develop a single point of referral for non-elective care that can ensure that clinical time is used productively to maximise patient safety and drive effective use of resources

- Support the delivery of integrated provision across health and social care to support the right interventions without having to transfer people between multiple care settings
- Work with acute providers to ensure that new GP streaming opportunities at the front door of A&E to maximise the use of new pathways and to not admit patients who can be supported within their home or usual place of residence
- Drive for a sustainable solution that ensures that investment benefits outcomes for patients without causing risks to organisations responsible for a wider range of care provision. We will use all contract options to incentivise value outcomes
- Retain our focus on Delayed transfers of care for our population throughout this process of change.

11.11 Acute Services

The enhanced management of people requiring complex care can deliver a sustainable system position that allows variation in activity levels – such as that experienced in 2017/18 – to be managed well without regular escalation. Not only does this benefit the local population and their health, but also staff and organisations:

- Acute Care
- GP streaming
- Frailty Unit
- 23 hour non admitted pathways
- Full ambulatory pathways coded as non-admissions
- Increase in short stay beds for frailty support (local tariff to increase nursing and discharge support resources for frail patients)
- Approach to ICD10 diagnostic codes identified in the coding and counting letters.

12. Complex Needs

The transformation of services for people with mental health needs and those with learning disabilities has been a central focus for the system in 2017/18. The work has been characterised by a new level of integration between health and social care to ensure a strategic approach to outcomes and a determination to eliminate the barriers that prevent service users and their families from stepping up at times of need and flexing their care arrangements.

In 2018/19 the CCGs will:

- Review all historic pooled arrangements and ensure that resources are aligned to maximise outcomes across care pathways
- Ensure that outcome based contracts are used to address the support required to:
    - Provide access to primary and usual health care services
    - Mitigate and manage crisis presentation and pathways

    - Focus on sustainable recovery
    - Maximise independence and self-determination with access to personal budgets and other solutions

- Commission a new set of arrangements to ensure that:
    - The local population is known and understood
    - People receive an integrated assessment approach
    - The market can operate within a single outcomes framework that reflects the needs of the population and the system approach
    - The market can work with a single integrated approach to secure appropriate care and support arrangements
    - Early intervention and rapid de-escalation of crisis can be supported, with resource following the patient rather than being dispersed

Considering the work undertaken in 2017/18, these programme areas, across all settings, are considered to be a significant opportunity to demonstrate how to drive improved outcomes, in line with national transformation plans and local knowledge, with a mind to an Accountable Care model and an Outcomes Based Commissioning Framework.

The CCG will therefore:

- Work alongside procurement requirements
- Work to agree the necessary legal framework to support the pooling of resources
- Look for innovation in outcomes based contracting through a new dialogue with the local population
- Support innovation across the market in response to commissioning plans

This approach supports consideration of pooled resources including complex budgets such as Continuing Health Care/Children's Continuing Care.

13. Next Steps

This document is supported by two key appendices:

1. Our clinical pathways and interventions across care settings
2. Our Local Maternity Services Plan with associated specific intentions

The CCGs will work with the system and public to develop the more detailed plans for delivery in 2018/19 and issue the Operating Plan and Contracts in line with national requirements.

APPENDIX 1

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
Stroke	• Smoking cessation • Weight management • Alcohol • Exercise (social prescribing) • Health Apps (Telehealth) • Opportunistic screening for Hypertension • Risk Factors management • Carer support	• Management and register maintenance to expected prevalence levels of Hypertension • NHS HealthCheck • Identification of high risk of stroke patients and detection of undiagnosed AF patients • NOAC initiation	• Stroke Prevention through AF optimisation Warfarin clinics • Specialised mental health support	• Increasing resource into Community Stroke Team and Early Supported Discharge Teams and work with NCC, social and voluntary care as part of Stroke Programme Board in designing new model and understanding impact e.g. demand on domiciliary care • Carer support	• Reconfiguration plan that aims for one single hyper acute and acute service for Northamptonshire and vision for single site acute stroke provision
MSK	• Self-Management Programmes - access to information, education and advice including and appropriate signposting to obesity management and	• Supporting primary care in management of MSK conditions through clear clinical pathways • Ensuring referrals are routed correctly for onward triage	• Clinical Review of GP referrals through MSK Triage • Joint injection	• Integrated specialist MSK triage, assessment, investigation and management • Physiotherapy and orthotics	• Hospital-based specialist MSK intervention and immediate rehabilitation

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
	exercise programmes • Maintain Independence – equipment	including diagnostics			
Diabetes- Adult	• Self-Management Programmes - access to information, education and advice including and appropriate signposting to obesity management and exercise programmes • Health Apps (Telehealth) • Diabetic eye screening (NHSE commissioned)	• Identification of patients at high risk of diabetes and referral to diabetes prevention programme DAFNE and DESMOND, through proactive/opportunistic screening and NHS HealthCheck • Diabetic register and optimising control • Referral to Pre-diabetic management programmes	• Optimal management of patients with diabetes through eight care process/NICE treatment targets • Insulin initiations	• Integrated delivery of community MDT across federation/primary care homes • Insulin Pumps • Diabetic high risk foot management	• Hospital-based specialist diabetes intervention and immediate rehabilitation for complex chronic patients • Acute Management of life threatening complications e.g. AKI/DKA • Diabetic eye treatment
Cancer	• National Cancer 'Be Aware' Campaigns; • Link in with 'First for Wellbeing' Work; • Work with patients with symptoms where	• Review Referral rates through peer-to-peer; • Support for Cancer Survivors • Use of diagnostics pre-referral including FIT	• Training e.g. PLT • Physiological support • Care planning • Hormone Therapy • MDT- proactive care • Teachable moments	• Community Cancer support services (incl. complex End of Life care provision- late diagnosis) • Counselling	• Optimal Lung pathway (subject to Alliance bid) • Screening/early detection

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
	'no abnormality detected' but with risk factors. • Screening/early detection	• Screening (PH) • Optimal detection 2WW note Nice guidance • Cancer care review • Palliative Care • End of Life Care • FIT colorectal screening introduction (subject to Alliance bid) • Screening/Early detection	for near miss events with patients • Data review • Reflections on diagnosis and referrals • Screening/Early detection	Survivorship support • Day Hospice • Hospice at Home • Lymphedema support • Expand Chemotherapy at home options • Palliative Care in-reach to acute trusts to expedite discharge • Screening/early detection	
CVD- Not Stroke	• Smoking cessation • Weight management • Alcohol • Exercise (social prescribing) • Health Apps (Telehealth)	• Health coaching • AF management • Drug optimisations • AAA screening • NHS Health checks	• Echo reading • LTC support and MDT management • Increased HF nursing support including RV capability • End of Life Care provision • Peer Support • Palpitations • Palpitations pathway • Ambulatory BP checks	• HF nurses including RV • Stroke rehab (day op?) • Cardio respiratory rehab • Stroke outreach IV diuretics • Repeat Potassium checks	• Prior approval for PCI • Outreach support to Integrated Community Heart Failure

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
Vision	• Screening for disease-specific eye conditions such as diabetic retinopathy. • Enhanced working with NHSE to support Optometry improvements	• Routing Management of acute presentations	• Clinical review of referrals • Urgent Eye appointment at hub level- Review and triage of referrals to support onward treatment decision	• Extend community provision of eye care through enhanced optometrists • New community pathways to treat non-complex interventions close to home	• Acute referral service to cover accidents and emergency issues
CYP Emotional Wellbeing/CAMHS	• Schools Screening/ Early Prevention • Social Marketing • CYP Counselling • Health Apps (Telehealth) • Online Advice Portal (e.g. AskNormen)	• Crisis planning and management • Brief interventions solution focused.	• Psychology • DBTCBT • Psychoeducation re symptom management etc. • CYP Counselling	• Family work/support • Psychotherapy • Psychology • Crisis Cafes	• Psychology • Inpatient wards • Crisis Home Treatment Teams • Group Therapy • Self- harm pathway
Depression	• Third sector counselling • Peer support • Debt counselling housing • Smoking cessation • Weight management • Training /Employment Support	• Brief interventions solution focused • Drugs and prescribing • Psycho-education programmes	• IAPT, Enhanced IAPT- (IAPT +Social Prescribing) • Peer Support	• CMHT, crisis services • Crisis cafes • Drugs /alcohol (dual diagnosis support)	• Psychology • Inpatient wards • Crisis Home Treatment Teams

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
	• Online Advice Portal (e.g. AskNormen)				
Psychosis	• Third Sector counselling • Peer support • Finance training and debt counselling, • Housing and tenancy support, • Smoking cessation • Weight management • Training /Employment Support • Carer support	• Crisis planning and management • Drugs management • Brief interventions solution focused	• Psychology • Psycho-education re. symptom management etc.	• CMHT • Drugs /alcohol (dual diagnosis support) • Talking Voices (Peer Support Groups)	• Psychology • Inpatient wards • CMHT's • Early Intervention in Psychosis (EIP) • Acute Liaison Teams (in reach) • Crisis Home Treatment Teams
Dementia and Mild Cognitive Impairment	• Alcohol Harm reduction • Smoking cessation • Weight management • Exercise (social prescribing) • Reducing social isolation • Supported Housing • Housing(extra care) • Falls Prevention • Assistive Technology(Telehealth	• Early screening and case finding • Health Coaching • AF management • Drug optimisations • LTC disease register • Frailty DES • Risk stratification tools • Carer Support	• Shared Care (step down from Memory Services for pts with Cognitive Enhancers) • Shared care for low /moderate need pts • Admiral Nurses in Primary Care • Carer support	• Admiral Nurses • Integrated OPCMHT's • Psychology • Care Homes • Care Home Psychiatric Liaison • Pro-active Care Planning including escalation management plan • Carer support	• Integrated OPCMHT's • OPMH Inpatient Wards • Frailty Units /Complex Ageing Unit • Short stay wards • Ambulatory care • Speciality in reach to A&E • 23 hour non-admitted area • Community in reach • Geriatrician outreach

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
	and Telecare) • Carer Support • Online Advice /Support Sporting Memories (targeted social prescribing) • Carer support				to Primary Care/Care Homes
Anxiety	• Exercise (social prescribing) • Third sector counselling • Peer support • Debt counselling • Housing • Smoking cessation • Weight management • Employment Support • Online Advice Portal (e.g. AskNormen)	• Crisis planning and management • Brief interventions solution focused. • Drugs and prescribing • Weight management • Psycho-education programmes • Peer Support Groups	• Peer Support • Psychology • DBT • IAPT • Psychoéducation to support symptom management etc.	• CMHT, crisis services • Crisis cafes • Psychology	• Specialist Psychology • Specialist Inpatients Unit
Eating Disorders	• Schools Screening/ Early Prevention • Social Marketing • CYP Counselling • Health Apps (Telehealth)	• Crisis planning and management • Brief interventions solution focused.	• Psychology • Psycho-education re symptom management etc. • CYP Counselling	• Family work/support • Group Therapy • Psychotherapy • Psychology	• Specialist Psychology • Inpatient wards • Crisis Home Treatment Teams
Learning Disabilities	• PBS training for families and carers • Employment support • Active support	• Annual Health Checks and Action Plans • Weight management • Smoking cessation	• Community Team for People with LD • Maternity support services	• Intensive Support Team behaviour therapy adults and children	• Inpatient wards for people with acute mental health needs • Buddying systems

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
	• Buddying systems for people and their families • Drop in centres or wellbeing café • Health apps assisted technology • Family support groups • Specialist teams and portage • Job coaching and mentoring • Easy read website local information • Keeping safe • Community connectors	• Trained pharmacies	• Strategic Health Facilitators • Counselling services • Sexual health programmes • Trauma counselling • Specialist skilled dentists • Dysphagia assessments • Health navigators • Enhances personal assistants	• Community Team for People with LD • Respite services for PMLD • Autism and Asperger's Service • CCG Complex case managers • Peer support groups • Psychotherapy • Specialist nursing homes for people with dementia/ physical poor health and end of life • Transition counselling and buddying and navigator • CAMHS support for families - family therapy • Specialist forensic support	• Assistive technology • Short term emergency stay units
Autism	• PBS training for families and carers • Employment support • Active support • Buddying systems for people and their	• Referral of suspected cases • Management of physical and mental health comorbidities	• Life coaching • Enhances personal assistance	• Intensive Support Team behaviour therapy adults and children • Respite services for people in transition	

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
	families • Drop in centres or wellbeing café • Health apps assisted technology • Family support groups • Specialist teams and portage • Job coaching and mentoring			• Autism and Asperger's Service • Peer support groups • Sheltered short term support • Wrap around crisis support	
Complex care	• Smoking cessation • Weight management • Alcohol • Exercise (social prescribing • Reducing social isolation • DESMOND/DAFNE etc. • Housing	• LTC disease register • Frailty DES • Risk stratification tools	• End of Life Care provision • NEL MDT • Pro-active Care Planning • Specialist nursing support • 2-20% risk stratification • Mental health support • Physiological support for pain management and End of Life Care	• Acute outreach • Increased wrap around- CCT and ICT home based. • Make core service dementia and cognitive confusion capable. • Day rehab outcomes Therapy Outcome Measure (combined Health and Social Care) • CHC – • Nursing home and Res home support.	• Frailty units • Short stay wards • Ambulatory care • Specialty in reach to A&E • 23 hour non admitted area • Community in reach
Minor Procedures	• Self-management and care	• New Community Surgery contract • Referral management	• New Community Surgery contract to include scoping other	• Minor injuries	• Prior Approval for inguinal hernias

Pathway	Prevention/Self management	Primary Care	Enhanced Primary Care/ Primary Care Home	Intermediate Services	Secondary Care
		system to support clear signposting to services	community services such as the current community continence service for adults in relation to urology • Minor injuries		
Carpal Tunnel Syndrome	• Self-management and care	• Treatment in primary care to be aligned to NICE guidelines	•	• Movement of CTS service into the community including diagnostics	• Prior Approval for diagnosis and management of CTS
Lower Urinary Tract Symptoms	• Self-management and care	• Review of primary care service provision	•	•	•
Respiratory **(Breathlessness)**	• Smoking cessation commissioned via Public Health • Making Every Contact Count (MECC) • Self-management and care • Anxiety management support • rehabilitation	• QOF indicator monitoring for Asthma & COPD • Flu immunisation • Standby meds • Disease register improvements against expected prevalence	• Secondary prevention care packages for COPD and asthma • None Elective MDT-proactive care • Consultant Connect	• Breathlessness pilot: psychosocial community drop-in clinics • Re-procurement of home oxygen service in 2018/19 • Advice to the collaborative care team from the Rocket team • MDT working with other specialities e.g. Cardiology	• Re-purposing opportunities for integrating services across pathway including ROCKET/RESTART and consultant outreach/ primary care education

Children with Complex & continuing care health needs	• Advice to parents & C & YP in collaboration with universal services at every health and social care contact. • Imms and Vacs • HV & School Nursing	• Development of Integrated Locality Hubs to cover all immediate on the day demand & compliance with SEND statutory requirements for working with partners to develop and deliver robust EHCPs & CC packages. • LTC monitoring • Hot Kids options • Safeguarding	• Development of Locality Hubs to cover all immediate on the day demand, with rapid response children's community nursing service • Extended options when parent return home to access care • Child protection issues	• GP Front Door Assessment; Up to 4 hour ambulatory assessment - & specialist paediatric discharge support to children with common and complex & palliative care needs. • MDT community clinics (routine appointments suitable for up to 4 week wait) • Catch Team	• Inpatient Wards Urgent OP Clinic Slots • Speciality outreach support to community paediatrics model • SPA.