AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 18th March, 2015, at 6.30 pm Ask for: **Ann Hunter**

Darent Room, Sessions House, County Hall, Maidstone Telephone **03000 416287**

Refreshments will be available 15 minutes before the start of the meeting

Membership

Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Mr E Howard-Jones, Mr S Inett, Mr A Ireland, Dr M Jones, Dr E Lunt, Dr N Kumta, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr R Stewart, Cllr P Watkins and Cllr L Weatherly

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in Items on the Agenda for this Meeting

In accordance with the Members' Code of Conduct, members of the board are requested to declare any interests at the start of the meeting. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared

4 Minutes of the Meeting held on 28 January 2015 (Pages 5 - 10)

To consider and approve the minutes as a correct record

5 Review of Commissioning Plans (Pages 11 - 272)

To discuss and endorse the following commissioning plans

Ashford and Canterbury & Coastal CCG
Dartford Gravesham and Swanley CCG
South Kent Coast CCG
Thanet CCG
Swale CCG
West Kent CCG
NHS England
Public Health

6 Better Care Fund Section 75 Agreement

To receive assurance that the Section 75 Agreement will ensure delivery of the desired outcomes of the Kent Better Care Fund Plan.

7 Pharmaceutical Needs Assessment (Pages 273 - 276)

To approve the final Pharmaceutical Needs Assessment for publication

8 Revised Protocol on the Working Arrangements between the Kent Health and Wellbeing Board, Kent Children's Health and Wellbeing Board and Kent Safeguarding Children Board (Pages 277 - 284)

To agree the revised draft protocol

9 Minutes of the Local Health and Wellbeing Boards (Pages 285 - 320)

To note the minutes of the local health and wellbeing boards

Ashford – 21 January 2015

Canterbury and Coastal – 27 January 2015

Dartford Gravesham and Swanley – 17 December 2014 and 11 February 2015

Swale – 28 January 2015

Thanet – minutes of last meeting on 12 February 2015 not yet available

West Kent – 20 January 2015

(The minutes of the most recent meeting of South Kent Coast HWB not yet available)

10 Date of Next Meeting - 20 May 2015

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

Tuesday, 10 March 2015

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KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 28 January 2015.

PRESENT: Mr I Ayres, Dr B Bowes (Vice-Chairman), Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Dr M Jones, Dr E Lunt, Dr T Martin, Mr P J Oakford, Dr M Philpott (Substitute for Dr F Armstrong), Cllr K Pugh (Substitute for Mr A Bowles), Dr R Stewart and Cllr L Weatherly

IN ATTENDANCE: Ms J Frazer (Programme Manager Health and Social Care Integration), Ms F Kroll (Director, Early Help and Preventative Services), Mr M Lemon (Strategic Business Adviser), Ms K Sharp (Head of Public Health Commissioning), Ms M Varshney (Consultant in Public Health), Mr T Wilson (Head of Strategic Commissioning (Children's)) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

120. Chairman's Welcome
(Item 1)

There were no announcements.

121. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr F Armstrong, Cllr A Bowles, Mr Gough, Dr N Kumta and Mr S Perks. Dr M Philpott and Cllr K Pugh attended as substitutes for Dr Armstrong and Cllr Bowles respectively.

122. Declarations of Interest by Members in Items on the Agenda for this Meeting
(Item 3)

There were no declarations of interest.

123. Minutes of the Meeting held on 19 November 2014
(Item 4)

(1) Dr Bowes confirmed that the Joint Health and Social Care Assessment Framework for 2014 had been signed-off by Mr Gough for submission in January 2015 as agreed at the last meeting.

(2) Resolved that the minutes of the meeting held on 19 November 2014 are correctly recorded and that they be signed by the Chairman.

124. Strategic Workforce Issues
(Item 5)

(1) Philippa Spicer (Local Director of Health Education England) introduced herself and said that Health Education England had been established in mid-2012 with responsibility for the education and training of staff in NHS funded services and care. She gave a presentation which set out the Kent context, profiles of the workforce, workforce trends and some examples of service transformation.

(2) A copy of the presentation is available on–line as Appendix A to these minutes

(3) In response to a question she said that remuneration and accommodation packages had been used in the past to attract doctors to the area and continued to be available to support their rotation as part of their learning and development, however any such packages had to be sustainable and should be looked at in conjunction with providers She also said work was being undertaken to encourage young people to consider careers in health.

(4) She said discussion about the nature of future services and the projected population growth was required to plan appropriate recruitment and training as was detailed information about the skills required to facilitate the ambition to provide care closer to home.

(5) It was generally accepted that Health Education had a role in ensuring that Kent attracted sufficient GPs to meet the needs of the projected population and that CCGs needed to articulate more clearly the skills required for the future and the training that should be provided as well as using their contacts with providers to assist Health Education with the provision of good quality placements.

(6) Dr Bowes thanked Mrs Spicer for her presentation.

125. Early Years Restructure
(Item 6)

(1) Thom Wilson (Head of Strategic Commissioning) introduced the report which set out a series of recommendations to refresh a partnership approach to children and young people's services across the county and aimed to start a conversation about how best to do this.

(2) Florence Kroll (Director of Early Help and Preventative Services) gave a presentation which included: a definition of early help; a brief description of the changes required, the design principles, values, aspirations; the partnership landscape and information about some achievements between September and December 2014.

(3) The presentation is available on-line as Appendix B to these minutes.

(4) During the discussion that followed, the role of children's operating groups and their relationship with the Children's Health and Wellbeing Board was raised.

The complexity of partnership arrangements and the opportunities arising from the transfer of responsibility for the Family Nurse Partnership and health visiting services were acknowledged. It was also suggested that a workshop be arranged to enhance the understanding of the legal responsibilities of all partnerships.

(5) Resolved that

(a) All partners review the membership of the Children's Health and Wellbeing Board and identify appropriate representatives to ensure they were able to effectively represent them and help steer the strategic direction for children's services in the county;

(b) The Children's Health and Wellbeing Board reviews Outcome 1 of Kent's Health and Wellbeing Strategy – Give Every Child the Best Start in Life to ensure it meets the strategic priorities of the organisations involved, and could be used to drive the delivery of the most important priorities for the county;

(c) The arrangements for working together at a local level be reviewed in partnership across the Districts, clinical commissioning groups and the Kent Safeguarding Children Board to quickly establish local governance which is meaningful and effective for all partners;

(d) Public Health commissioners, in partnership with all colleagues across the Health and Wellbeing Board, refresh and re-develop the model for health visiting to deliver an integrated service for families with young children;

(e) Working together Early Help & Preventative Services and health commissioners would agree the actions and programme of work to achieve the priorities of the Healthy Child Programme;

(f) A workshop be arranged to understand the complexity of partnership arrangements, the corporate and legal responsibilities of partners, share learning and understand how best to hold people to account for service delivery.

126. Integration Pioneer Update and Vision re the Five Year Forward View
(Item 7)

(1) Dr Robert Stewart introduced the report by giving a short presentation which is available on-line as Appendix C to these minutes.

(2) He referred, in particular, to system leadership workshops to decide future working of the Integration Pioneer, the visit of Simon Stevens (Chief Executive of NHS England) to the Kent Integration Pioneer on 24 February 2015 and examples of innovation in Kent. He said that Thanet was not working towards the development of a hybrid PACS as had been stated in the Powerpoint slide

(3) Resolved that the report be noted.

127. A - Assurance Framework B - Update on Quality
(Item 8)

A – Assurance Framework

(1) Malti Varshney (Consultant in Public Health) introduced the report which provided performance information on a suite of indicators based on the Kent Health and Wellbeing Strategy and additional stress indicators. She drew the board's attention, in particular, to indicators relating to bed occupancy rate by Trust and by speciality and the percentage of A&E discharges, admittances or transfers within 4 hours by Trust. She said the figures relating to A&E discharges for December, which had become available since publication of the report, showed an improvement.

(2) During discussion about demand for services over the Christmas period, it was reported that West Kent had been extremely busy with 30% more admissions than on a normal Sunday but the system had been able to absorb this increase because of the commitment of all partners. It was also said that it was important to validate the perception that increased acuity was driving the increase in admissions.

(3) With considerable effort East Kent had been able to maintain its performance at 89.3% and had followed this up with a "perfect week" exercise which confirmed that it had been the commitment of all partners that enabled performance to be maintained. A further "perfect week" exercise was planned for March to understand the capacity required, workforce issues across all partners and whether there might be a need for "sub-acute" capacity.

(4) The Darent Valley Hospital was the only Trust to achieve the targets set for quarter 1 and quarter 2 and the Integrated Discharge team had played a significant role in avoiding the need to move into major incident mode and in enabling the Trust to recover quickly from increased demand, particularly the 40% increase in the admission of elderly patients compared with the same period last year. Ms Davies also said that Secamb had seen an increase of 40-50% in activity levels above projected levels which had resulted in issues covering some shifts. For the first time ever IC24 and Meddoc had difficulty covering shifts and had been let down by agencies.

(5) Work to improve performance at Medway NHS Foundation Trust was continuing. Activity had reduced over the last couple of weeks and consequently performance had improved.

(6) Social care services had seen an increase in activity too and, although the general response had been good, there were issues relating to workforce, particularly in domiciliary care, which may be related to the increase in acuity and the need for double handed care packages.

(7) Resolved that:
(a) The report be noted;

(b) A robust analysis of trends be undertaken to understand what was driving demand with a report to a future meeting of the HWB.

B – Update on Quality

(8) Steve Inett (Chief Executive – Healthwatch Kent) gave a presentation on the progress made to produce a quality report that fulfilled the requirements set out in the Francis report. A copy of the presentation is available on-line as Appendix D to these minutes.

(9) Resolved that:

(a) The Quality Report highlighting the complex systemic issues that have the most impact on providing high quality services in Kent be noted;

(b) Healthwatch Kent contacts representatives from commissioners, providers and working groups to gather feedback on the main issues of concern;

(c) Healthwatch Kent presents a further report analysing the issues and identifying key trends.

128. Better Care Fund - S75 Agreement
(Item 9)

(1) Jonathan Bates (Chief Financial Officer – South Kent Coast and Thanet CCGS) introduced the report. He said the £100m available across Kent represented a substantial start towards the integration of services, and that the government's initial approach to the BCF had been based on a 3.5% reduction in urgent care admissions to acute hospitals with the resulting savings available for the BCF to develop integrated health and social care. More recently health organisations had been asked to identify an appropriate target band for the first year. Following discussions with CCGs, and taking into account performance for the year to date as well as the projected population growth, it was proposed that the target band of 0.6%-1% be set for Kent.

(2) During discussion, there was general support for the proposed target band, however the importance of maintaining local ambitions and delivering the positive outcomes set out in commissioning plans was emphasised. The need to understand local relationships, establish them quickly and to ensure good governance arrangements were in place (including robust quarterly reporting to the Kent HWB and to local health and wellbeing boards) was identified.

(3) Resolved that the progress made to date on developing the section 75 agreement to support the delivery of the approved BCF plan be noted.

129. Minutes of the Children's Health and Wellbeing Board
(Item 10)

Resolved that the minutes of the Children's Health and Wellbeing Board held on 28 November 2014 be noted.

130. Minutes of the Local Health and Wellbeing Boards
(Item 11)

(1) It was reported that Ashford HWB had met on the 21 January and that the minutes would be available shortly.

(2) Resolved that the minutes of the meetings of the local health and wellbeing boards be noted as follows:
Canterbury and Coastal HWB - 25 November;
Dartford, Gravesham and Swanley HWB - 29 October;
South Kent Coast HWB – 16 September and 25 November
Swale HWB – 19 November
Thanet HWB – 13 November
West Kent HWB – 18 November

131. Date of Next Meeting 18 March 2015
(Item 12)

Appendices available on-line

Appendix A–	Strategic Workforce Issues
Appendix B	Early Years Restructure and (Integrating the approach of Children and Young Peoples Services
Appendix C	Integration Pioneer Update and Vision re Five Year Forward View
Appendix D	Update on Quality

Planning for Tomorrow, Delivering Today

Operating Plan 2015/16

Executive Summary

A PICTURE OF HEALTH

NHS Ashford Clinical Commissioning Group

NHS Canterbury and Coastal Clinical Commissioning Group

In October 2014, NHS England published "Five Year Forward View" (5YFV), which set out their vision for services over the coming five years. This highlighted that the divide between primary care, community services, hospitals, social care and mental health services are increasingly a barrier to the personalised and coordinated health services patients need.

5YFV identifies that, in order to meet patients' needs and expectations, we need to dissolve these traditional boundaries. Long term conditions are now the central focus of the NHS commissioners; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking:

•Increasingly we need to manage systems – networks of care – not just organisations.
•Out-of-hospital care needs to become a much larger part of what the NHS does.
•Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
•We should learn much faster from the best examples, not just from within the UK but internationally.
•And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Community Networks

Both NHS Ashford CCG and Canterbury and Coastal CCG are in a good position to deliver against these expectations. Our five year strategic vision, which was published in 2014, clearly sets out our intention to transform our services towards a more community centric approach through our Community Networks approach.

Multispecialty Community Providers

5YFV also reflects on provider models, specifically looking at our primary care services. Locally, we are currently developing our strategy for Primary Care which reflects this challenge. The past few months has seen our GPs meeting this challenge head on, and in February 2015, our members submitted four separate bids to NSH England's "Forerunner" programme to become part of the first wave of this significant change to care models. Each of these bids identifies how practices could work as wider groups (in line with our Community Networks programme) and potentially employ consultants, or take them on as partners, and a wider range of health professionals to work alongside existing primary care, community nurses, therapists, pharmacists, psychologists, social workers, and other staff. These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

Our Strategic Plan on a Page

"Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector."

- Securing additional years of life for the people with treatable mental and physical health conditions.
- Improving the health related quality of life of people with one or more long-term condition, including mental health conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
- Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.
- Ensuring a sustainable financial future and good governance
- Effective stakeholder engagement, public engagement and partnership working.

Primary Care	**We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.**
Community Networks	Primary and community care services working closer together, along with voluntary organisations and other independent sector organisations.
Mental Health	We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities
Urgent Care	We want care that crosses the boundaries between primary, community, hospital and social care.
Maternity, Children and Young People	We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation
Planned Care	We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

Governance

- Governing Body and supporting committee structure
- Kent Health and Wellbeing Board
- Canterbury and Coastal Health and Wellbeing Board with supporting sub-group structure
- Whole Systems Delivery Board
- Public Reference Group
- Programme Boards for Urgent and Planned Care
- Programme Management Office

Success Criteria

- Delivery of improvements against NHS Operating Framework Domains
- Achievement of financial stability and balance
- People are supported to live in their own homes or communities.
- We will see less acute admissions and reduced length of stay.
- Carers are be supported and have access to services as appropriate.
- We will have systematised self-care so that *people can to manage* their own health and social care needs

High Level Risks

- Ensuring that we have a workforce with skills to deliver integrated care.
- Ability of providers to respond to competing priorities
- Maintaining quality and safety during period of service transformation
- Achievement of financial balance
- Public support for change programme

Safeguarding

Maintaining a focus on safeguarding for the most vulnerable groups is a priority concern for the CCGs and we will continue work in partnership with all stakeholders to ensure statutory responsibilities are undertaken as effectively as possible. In particular:

- To host designated safeguarding leads for both adult and child within the CCG with direct access to the chief nurse to share and escalate concerns.
- Quality In Care homes project
- To host CAF (Common Assessment Framework) completed by health Services on behalf of vulnerable children and families.
- Learning disabled residents care and placements are reviewed in response to the Winterbourne View Findings.
- Chief Nurse ensures the CCG has a designated representative to the Safeguarding Adults Board and Health Safeguarding Group (a Sub group of Kent Safeguarding Children Board)
- Designated doctor for safeguarding children and a designated paediatrician for unexpected deaths in childhood provide CCG advice and support
- Assurance in place for providers meeting safeguarding child and adult training.

We will continue to work closely with our local authority partners to continually improve the safeguarding of children and vulnerable adults and to continue to be active members of the local safeguarding boards to maximise opportunities for greater coordination and integration of adult and children's safeguarding arrangements

Care Quality Commission

Across east Kent we pride ourselves on commissioning and providing excellent care for our patients. When we fail to live up to our own high standards, we look to rectify the position. During 2014-15, local providers have been assessed by the CQC and as a consequence have introduced actions plans to address shortfalls in performance.

East Kent Hospitals

The action plan resulting from the inspection is focussed on recruitment and retention of clinical staff, ensuring policies are up-to-date and communicated widely with staff, that the environment and equipment used for treatment is maintained to a high standard, waiting times for treatment are reduced and that reporting structures for incidents and risks are refined.

Kent Community Health

The action plan resulting from the inspection is focussed on end of life care, children's services, recruitment and staff retention, care planning and that the environment and equipment used for treatment is maintained to a high standard.

We continue to monitor progress against both of these action pans.

Management of Serious Incidents (SI) and Never Events

All Serious Incidents and never events are reviewed and discussed by the quality committee.

The CN together with the Quality Lead monitor these alerts and ensures the providers act accordingly to review and understand the root causes of the SI and ensure that action plans are in place to minimise recurrence.

We will encourage a culture of transparency, openness and candour across the health system, to ensure that staff, patients and carers feel safe and secure when raising concerns and that we learn from patient safety incidents and 'never events' to prevent them from happening again.

Healthcare Associated Infections

We will continue to reduce the number of Health Care Associated Infections (HCAIs) through the implementation of local action plans and we remain committed to a zero tolerance approach. We will employ expert resource in this field to bridge the gap between primary and secondary care and ensure that learning can be embedded throughout the health and social care sector.

The priorities set out in our 2014/15 operational plan were developed in consultation with local residents and informed by Kent County Council's Joint Strategic Needs Assessment (JSNA), the local health and wellbeing strategy and national policy. Each priority was led by a GP Clinical Lead and supported by a team of commissioning staff. Patient and public views were incorporated in both the setting of these priorities and as the work programme emerged which ensured that a patient and clinical perspective was at the core of every discussion and decision.

Commissioning Projects

During 2014/15 we have focussed on ensuring that we have the correct processes and governance in place to deliver against our stated plans. Our commissioning projects were designed to put the foundations in place, allowing for stabilisation during 2015/16 and significant transformational change during 2016/17, supporting people to look after themselves within their local community.

To this end a number of projects have been delivered during the first year of our plan. Examples of these are:

Long Term Conditions

Community Networks have been set up, we have increased our dementia diagnosis rates, our care homes projects have led to a reduction in urgent care attendances and admissions

Mental Health

Primary Care base mental health workers are now in place, supporting individuals within their community and we have made significant progress in increasing recovery rates with our IAPT services whilst also reducing waiting times.

Urgent Care

Whilst we underachieved against our constitution standards, we have been building the capacity for the future. Our new integrated discharge teams ensure that patients do not face delays in having care packages in place for their timly discharge following inpatient care. Our Local Referral Unit ensures that patients are offered support within their own homes instead of requiring admission to hospital and we have also trialled weekend opening for general practices across both CCGs.

Financial Successes

Both CCGs achieved a small underspend against our allowed budget for administration and management costs. This allowance is a reduction from previous Primary Care Trust limits In accordance with the "Better Payment Practice Code", the CCG exceeded the target of paying 95% of its invoices within 30 days.

The NHS Constitution identifies a range of standards to which patients are entitled and which we are committed to deliver. We underachieved against four of our key constitutional responsibilities and have therefore put in place a serious of measures to correct this position. Our assumption is therefore that we will be fully compliant with these standards from Q1 of 2015*/16, demand management schemes are in plan and no additional funding is required other than that already set out within our activity and financial plans.

A&E

There is a good understanding of the issues and detailed plans which show compliance for Q4 of 2014/15. We have used our resilience funding to help achieve this and, in January 2015, we implemented a 'Perfect Week' exercise, supported by the across the health economy.

Diagnostic

There is a good understanding of the issues which are predominately associated with the workforce now resolved. Our plans demonstrate compliance from November 2014. This plan also supports the compliance of the Cancer standards.

Cancer

There is a good understanding of the issues that have caused the deterioration in the performance and detailed plans set out for both the Trust to deliver and CCGs to support through joint clinical engagement on capacity reviews, patient pathways and referral processes.

18-wk Waits (RTT)

There is a good understanding of the general cause of the dip in performance. It is recognised that to sustain this longer term compliance with the RTT standard, a comprehensive, expert external review is required to better understand increasing demands (especially in Orthopaedics) and commission appropriate capacity going forward from 1 April 2015. This has now been jointly commissioned. The plan currently shows non-compliance throughout Q4 in order for us to treat those in backlog as a priority and enable compliance from 1 April 2015.

Governance

To ensure the ongoing maintenance we have revised our governance structures across the health economy. We have refined our contractual and performance monitoring arrangements and it has been agreed by all local NHS organisations and Kent County Council that the system resilience is maintained though the East Kent Program Delivery Board. This is a Board consisting of all major local NHS provider CEOs, AOs and clinical chairs of all four CCGs, Kent Director of social care and chaired by Kent County Cllr Roger Gough. This is a system level leadership board consisting of those with the ability to commit resources.

The CCGs received a reduced allocation from the autumn statement, 1.4%, with growth per capita below 1% and one of the lowest in the country. In 2015/16 the main challenge and risk concerns delivery of planned benefits from Quality, Innovation, Productivity and Prevention (QIPP) schemes.

NHS Ashford CCG

The plan balances in year, maintaining the 2014/15 surplus. However, it does not return the CCG to a 1% surplus within 15/16. A recovery plan has been submitted to NHS England in line with planning guidance. The plan details the actions being taken to address the longer term financial position of the CCG utilising the Right Care approach to deliver value in commissioning.

NHS Canterbury and Coastal CCG

The plan delivers a 1% surplus, but assumes return of surplus from 2014/15 to fund some non recurrent investments in Mental Health, Community networks (MCP development) and the Right Care program.

Activity

The contract with the main acute provider is being planned at the previous years contract and out turn level as appropriate, the CCGs have implemented referral management services and non elective changes that will maintain the activity at these levels. The QIPP reflects the work to maintain activity on or around the 2014/15 out turn, a number of schemes to reduce cost in pass through payments and reductions in activity in some services. The main activity reductions are within urgent care, with an expected reduction of between 2-5 admissions per site per day.

QIPP

Through revision of the planning and contract discussions with providers the QIPP target has been reduced to 2% for Canterbury and 3.1% for Ashford. This is still a significant challenge but is more in line with other CCGs planned savings. The majority of the QIPP is extensions of schemes that have started in the later quarter of 2014/15, such as the orthopaedics referral and triage scheme, however both CCGs require savings above those currently agreed. In total these two elements deliver the vast majority of the required QIPP (Commissioning for Value Schemes).

Mental Health

Mental Health contract with KMPT is being increase through further investment in additional bed capacity and the rebasing of the contract from fair shares. In addition the joint management of CHC patients is expected to increase the contract whilst generating overall savings to the health economy.

Winter Resilience Funding

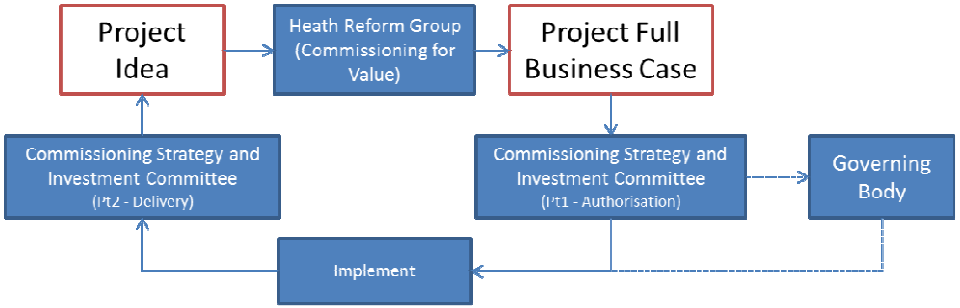
The winter resilience funding has been in held in reserve pending the outcome of the whole system review of the 2014/15 schemes for effectivity and value for money. When these have been ranked and agreed the most effective schemes will be implemented and funded.
The next tranche relates, particularly with EKHUFT, to jointly developed and agreed intentions..

Better Care Fund (BCF)

The BCF is being finalised with KCC and whilst the level of integration could be greater, KCC are integral partners in the community networks and the governance structures within the section 75 have been operating for the last year.

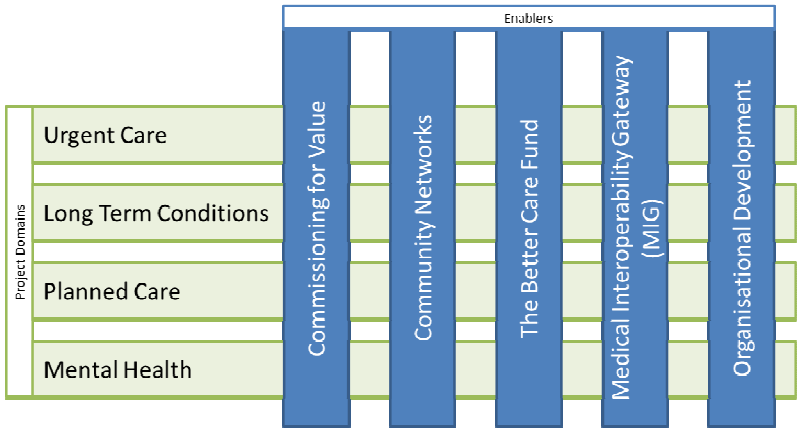
To ensure that the CCG remains focused on delivery of its plans throughout 2015/16 we have implemented the following tracking mechanisms.

•Initial project ideas to be tested against Commissioning for Value methodology
•Full Business Cases to be considered by Commissioning Strategy and Investment Committee, who will set review criteria at point of project authorisation
•Project progress to be reviewed by Commissioning Strategy and Investment Committee, in accordance with criteria previously set out
•Ongoing performance against plans , and lessons learned, used to generate new project ideas



The CCGs have recognised that in previous years we have attempted to effect change across too many fronts and have subsequently not have sufficient capacity to deliver the goals we have set ourselves.

Consequently, for 2015/16 we are focussing across a reduced number of projects in a matrix working approach. We will have five enabling projects addressing priority needs in four separate domains, as set out in the graphic



Draft Timelines

	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Urgent Care														
– Integrated Urgent Care Centre														
– Seven Day Primary Care														
– Achieving A&E Waits														
– Faversham MIU														
Planned Care														
– Achieveing RTT (MSK)														
– Personal Decision Aids														
– Cancer Waits														
Mental Health														
– Care Programme Approach														
– Achieving Partity of Esteem														
Long Term Conditions														
– Cardiology														
– Chronic Kidney Disease														
– Neurology														
– End of Life Care														
– Dementia														
– Reducing Community Nursing Demand														
Ongoing Projects														
– Diabetes														
– Falls Prevention and Treatment														
– Care Homes Support														
– Community Loan Store														
– Community DVT Service														
– Anti-Coagulation Service														

☆ Health Reform Group
☆ CSIC
☆ Implementation Commences
☆ First Review

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NHS Dartford Gravesham and Swanley CCG

Annual Operating Plan 2015/16 (Year two)

The Executive Summary

Introduction

Our Five Year Strategy and Two Year Operational Plan identify the key priorities for the period of 2014 to 2019. It incorporates the views of the public and our providers, and is in line with the Kent Health and Wellbeing Strategy to which we have contributed with our key local authority partners.

The CCG Vision is to be a clinically led and innovative commissioning organisation that puts patients first, improves their healthcare outcomes, and operates with minimal bureaucracy.

This vision cannot be delivered in isolation by the CCG, but requires a whole system approach to the delivery of care. The proposed commissioning intentions outlined within this plan, therefore, reflect the joint view and intentions from the Health Economy developed through partnership forums and clinically led workshops with providers.

Our Aim is to improve integrated care in the community that enables our GP members to be able to support, particularly, our older and more vulnerable patients more effectively both proactively and when a patient is in an acute crisis

Key to delivering this aim is our Better Care Fund plan, which has been developed with our partners (providers, Local Borough Council and Kent County Council) and patients. Elements of this plan have been introduced within 2014/15 to test out approaches to integrated working, such as the Integrated Primary Care Teams. We have established joint governance arrangements with our local partners and patients to oversee the implementation of these plans, and ensure ongoing commitment to commission and deliver care in a more integrated way.

Our Plan on the Page and Vision and Priorities (2014 – 19) diagrams (Appendix A) provides a summary of our five year strategy and high level details of the top priorities that we will be focusing on to ensure delivery of improved health outcomes for our patients.

Transformational change

The need for transformational, system wide change is clearly recognised, and as such, is a key element of the CCG plans going forward.

Our aim is to create a long-term sustainable health care system across DGS whereby primary, community, mental health and acute care (including SECAMb, NHS 111 and Out of Hours services) work seamlessly together with our General Practices, the local authority, Borough Councils, third sector and voluntary providers to deliver the health and well-being priorities for local people and their communities. At its heart it combines GP services with wider community-based services including social care, district nursing, mental health, pharmacy, step-down beds, reablement and domiciliary care services.

DGS CCG have applied to be a 'Vanguard' pilot, with this as a particular aim, to ensure that health and healthy living is made a priority in the planning of the **Ebbsfleet Garden City** development and that the rest of the local community is made sustainable, and not disadvantaged by this. We have a once in a life time opportunity to contribute to the design of good living space with health and wellbeing at the fore and new clinical delivery designed from scratch.

Our modern PFI hospital sits next to this development and is grounded in the local community, but needs an integrated solution to make it financially sustainable. And with our ageing population, we want to preserve people in their communities as long as possible, ensuring they are self-reliant and are able to access health and social care advice and information as easily as possible; but ensuring that care when needed is provided in the lowest intensity environment and as locally as possible. All

of this is at the heart of the *Five Year Forward* View. Becoming a Vanguard Pilot will extend and enhance the strong collaborative partnership that already exists across this community.

DGS CCG believes that both the multi-specialty community provider (MCP) model and the primary and acute care (PAC) system model could apply based on the requirement for:

1. A wider model of sustainability for D&G and, therefore, the wider DGS economy as described above; and
2. A solution for the Ebbsfleet Garden City which is a significant, new and rapidly emerging economy within DGS. This development is now underway; construction of housing has commenced with 150 dwellings already completed and a further 350 due for completion by the end of 2015. The pace of construction is expected to increase rapidly from 2016 and the area has capacity for 15,000 new homes. Initial analysis suggests that by 2025 the total effect of the housing development for DGS as a whole will be an increase in the overall population by 50,000 people. These will be predominantly concentrated in the Dartford/Ebbsfleet area, but also includes further growth projected for Gravesham and Swanley, separate to this development.

DGS have developed strong collaborative arrangements across acute and primary care in particular and with the health economy, social care, the local authority and Borough Councils. To this end, the local health economy commissioned the Kings Funds to complete a piece of work during 13/14 as part of the two and five year planning process. This work focused on what services would be required over a 5-year period to meet the changing needs within DGS based on projected demographics and effectiveness of prevention interventions, etc.

It was clear from this piece of whole system work that efficiencies can be made through reconfiguring the way care is delivered, with a greater focus on robust primary care, and stronger involvement of specialist care (hospitals without walls) within the community. Furthermore, efficiencies can and should be made in the way that community health and social care operate to provide more sub-acute care within community estates and integrated care within peoples' homes. In essence, seamless flow between organisations and professionals is critical, to enable timely and appropriate care in the community, rapid access to secondary care when required and equally rapid and safe discharge back into a patient's own home or the community. By following through the recommendations, the Kings Fund believes that the system and acute hospital could absorb an expanding DGS population.

The CCG has already made significant steps towards progressing integrated care services and by April 2016 will have;

- Enhanced the Integrated Discharge Team model and have a working and fully implemented network of integrated primary care teams in place across DGS. These will include district nursing, mental health services, social care and domiciliary care.
- completed an adult community services review based on a lead provider model, and by April 2016 expect to be in the process of implementing any changes arising from the review, with a specific focus on the integration model;
- Mobilised and implemented an agreed model for the Ebbsfleet Garden City development, including plans for the potential development of an integrated health and social care hub;
- An integrated electronic patient care record system between the primary, community and acute organisations, potentially including with the local ambulance service.
- Procured a new urgent care model that combines out of hours, minor injury units, walk-in centres and NHS 111services and integrates fully with primary care and ambulance service provision.

DGS has a good track record of developing and delivering new ways of working. This has resulted in the establishment of joint governance structures with the local authority such as the joint strategic and operational commissioning group, which reports directly into the CCG and Local Authority systems. This group drives clinical innovation, reviews respective plans for delivery and has been fundamental in the design and introduction of care pathways and the development of the Integrated Discharge Team and community based Integrated Primary Care Teams around general practice.

In addition to the above, the CCG has, with its North Kent CCG partners (Medway CCG and Swale CCG) developed the **North Kent Education, Research and Innovation Hub (ERIH)**, which brings together Health Education England, local academic partners, professional bodies and clinical leaders. The purpose of this forum is to look at innovative approaches to recruitment and workforce delivery to meet current requirements and support aspiring models, to stimulate local research and bring together joint strategies to education and training. This forum has forged strong partnerships with Royal Colleges and NHS Employers. Outcomes so far have been;

- an increase in the number of training practices within DGS,
- appointment of practice nurse tutors to provide opportunities to train both student and post graduate nurses in primary care, and
- placement of paramedics within primary care including the use of local GPs in paramedic training.

The forum has also supported practices in delivering health care research and can provide a vehicle for the evaluation of any emerging models.

Key Commissioning intentions (including Forward view into action focus on prevention)

The CCG has strong relationships with public health in KCC and recognises the unique value that the science of public health can bring. Given the modelling required and level of health inequalities within the community, the CCG has agreed to appoint its own public health consultant, not to take over the statutory role that is provided within the local authority, but to bring a wider science and systematic approach to the planning process and management of health prevention. The post is supported and has been approved by the Faculty of Public Health. An interim has been in post for the last year to test out this approach whilst the CCG has gone through the Faculty approval process. This DGS resource has significantly contributed to much richer, standardised data and evaluation of schemes and programmes. The post acts as an effective bridge between general practice and the local authority in terms of design and integration of preventative strategies and in the critique and evaluation of plans. (Note: Key public health programmes are identified in the refreshed Operating Plan).

Commissioning Intentions 2015/16

The plan on the page (*Appendix A)* identifies the key priorities and plans for the CCG for 15/16. This builds on the programmes and projects developed in 2014/15. The CCGs transformation plans (see above) identify the key areas of focus and the priority programmed that we will be working on. We believe that parity of esteem is important and we will continue to implement and develop support for patients (both children and adults) who suffer from mental health illness. Key areas for the additional mental health investment include:

- Investing in Liaison Psychiatry at Darent Valley Hospital A&E - £260k
- ASD investment - £84k
- Admiral Nurse as part of Older Adult Mental Health service - £50k
- Armed Forces contract investment related to Veteran mental health - £5k.
- Mental Health Placements – expected increase - £150k

The balance will be used for out of area placements or further investment in services as identified. Please see Appendix D for the commissioning intention programme summaries.

Finance Context and delivering value *(please refer to the Finance section in the 2year Operating Plan for the full detail)*

The CCG has now revised its financial plan in line with changes to resource allocation and expenditure demands. The CCG has received an additional £6.0m funding for distance from target that was not in the plan last year. This will be used for the transformational changes and investment that the CCG is under taking. This includes;

- Adult Community Services Review

- Urgent Care Review
- Vanguard Application
- Better Care Fund
- Patient Transport tender (transforming patient services)
- Investment in Mental Health

The CCG has also received 1.4% GDP growth of £3.9m, winter resilience funding of £1.5m and the Better Care Fund transfer of £4.8m. The CCG has a non-recurrent return of surplus of £3.9m. The CCG proposes to use Winter Resilience to fund the Integrated Discharge Team.

Allocation 15-16	**£ m**
Recurrent Baseline 14-15	277.4
1.4% Growth	3.9
Winter resilience	1.5
Distance from target	6.0
Better Care Fund (from Local Authority)	4.8
Running Cost Allowances	5.6
Total Recurrent Allocation 15-16	299.2
Return of Surplus	3.9
Total Allocation 15-16	**303.1**

QIPP 2015/16

The largest QIPP programmes in terms of financial gain are:

15/16 QIPP by Programme £ 000	**Saving**	**Investment**	**Planned Net Saving 2015/16**
Integrated	978	(151)	827
LTC	0	0	0
Mental Health	1,435	(65)	1,370
Planned Care	742	0	742
Prescribing	1,000	0	1,000
Primary Care	168	0	168
Urgent Care	1,143	0	1,143
(blank)	0	0	0
Other Investment	250	0	250
Total	5,716.2	(216.2)	5,500.0

The CCG has a robust demand and capacity model aligned with providers as we have been working as a whole system over the last 18 months. (*Appendix B provides further detail on the key commissioning projects linked to the programme areas*.)

Financial Risks

There are a number of risks associated with the indicative Budget for 2015/16, the key risks being:

1. The PbR tariff for 15/16 has not yet been released so all contract assumptions are on 14/15 tariffs adjusted for growth and deflation.
2. The NHS Standard Contract has not yet been issued. This will put pressure on the contract timetable, contracts are due to be signed on 11 March 2015.

3. Growth from Ebbsfleet Garden City and other social developments are not financially factored into this plan although the CCG is looking at the financial impact of such significant population growth.

Triangulation of Planning Returns

Key planning assumptions and operational plans have been applied consistently across the various planning submissions and their relevant sub-elements. However adjustments to finance and activity plans will not always be in direct proportion as; not all finance changes will have an associated activity impact; some activity related changes will not be measurable in the templates e.g. excess bed days and switches between long and short stay admissions; the activity returns themselves are related to General and Acute activity and so Mental Health and Community providers activity is excluded; activity for RTT, and other NHS Constitutional measures, does not match exactly to contracted elective activity which would include planned treatments, RTT exclusions etc.

Impact on Growth - Growth has been applied consistently across all relevant areas for 2015/16 at 1.5%, combining demographic and demand impact. This has been applied to forecasted activity, finance, referral and acute activity based NHS Constitution measure e.g. RTT and diagnostics.

Application of QIPP Schemes - The CCG's plans for QIPP schemes are at an individual project level, detailing planned implementation and delivery at a provider, point of delivery and specialty level. Development of these schemes is logged centrally on one document and includes both finance and activity impacts on phased basis. Whilst these are continually evolving documents, a point in time extract has been used for the planning documents and as such financial and activity impacts will be consistent in the templates. In addition the QIPP documents record whether schemes have an associated GP referral impact. Where schemes are highlighted as such the associated referral activity has been adjusted down within referral activity templates.

Activity Reconciliation with UNIFY Submission - As previously stated contracted activity does not correlate to NHS Constitution activity denominator levels. However planning assumptions have been incorporated into the trajectories included within the UNIFY submission. In addition where the CCG has highlighted the potential need for recovery plans to achieve Constitution measures this will be incorporated into the associated activity and finance templates in future iterations once the full impact is known.

Governance and Delivery in 2014/15

Collaborative Boards at Executive and clinical operational levels have existed for some time (reference: Governance section of DGS Five year Commissioning Strategy). These have resulted in a wide range of joint health and social care programmes, focusing on;

- the reduction of health inequalities through systematically targeted prevention strategies,
- improvements in primary care mental health services, and a real focus on dementia, and
- targeted support for the frail elderly and patients with long term conditions.

Such schemes have demonstrated tangible benefits over the last year in particular both in terms of improved care outcomes for patients, and improved performance delivery. These include:

- Our health economy has been one of the most stable in the country this winter and has seen activity growth contained through joint working and new clinical models;
- A real reduction in the number of patients being admitted into long-term care placements;
- A reduction in the number of duplicate care plans and services through the introduction of integrated teams;
- A corresponding increase in spend for reablement;
- A reduction in the number of patients converting to an acute hospital admission (reduction in conversion from c33% in Jan 2014 to c24% by July 2014 and this remains stable);
- An increase in the number of dementia patients being discharged from A&E back to their normal place of residency with health and enablement support and voluntary care support from the Alzheimer's and Dementia Support Service;

- Sustainable achievement of the 95% 4 hour A&E waits standard (and other NHS constitutional standards) within the local acute Trust.
- A health system where both commissioners and providers have delivered financial balance in recent years, but face a more uncertain future without new models of care

Quality and Safety

Quality and safety remains at the heart of the CCG. Linking across providers to improve the impact on the quality of care and the effect on patient safety and experience will be fundamental to the integration of health and social care going forward. As recommendations from the Francis, Berwick and Winterbourne reviews become mainstreamed and embedded as business as usual within organisations, the ongoing oversight of the actions will remain an essential part of the continuing monitoring with providers and for the CCG as an NHS organisation in its own right.

The CCG works with commissioned providers to monitor and assure the quality and safety of services and outcomes for patient experience. Within Dartford, Gravesham & Swanley CCG these providers are Dartford & Gravesham NHS Trust (D&G) and Kent and Medway Partnership NHS Trust (KMPT). The CCG also works closely with Swale CCG in relation to Kent Community Healthcare Trust (KCHT) and South East Coast Ambulance Service (SECamb). Across these providers the main focus areas include:

- **D&G Trust** - There are little concerns regarding this provider and the CCG continue to monitor through the CQRG meetings.
- **KCHT -** The CCG is working to gain greater assurance around Looked After Children (LAC) arrangements with the trust.
- **KMPT** - There are ongoing concerns relating to crisis management workforce as highlighted from deep dive into the service last year. This was also reflected at the recent CQC thematic review. The Trust are to have their CQC chief inspector of hospitals inspection in March.
- **SECamb** - Issues in relation to compliance with mandatory training targets and uptake of key workforce measures such as appraisal are an area of focus with the organisation.

DGS CCG has arrangements in place with Swale CCG and Medway CCG to collaborate on the functions of the Quality and Safety team which includes safeguarding children and adults. Swale CCG hosts the CCG's LAC service for the whole of Kent and Medway and the Child Death service for Kent (excluding Medway).

Further improvements in the reduction of Healthcare Associated Infections and learning from incidents of HCAI across Acute, Community and Mental Health, Primary and Social care will further improve the reductions achieved to date.

NHS Constitution performance

As at December 2014 DGS CCG has met all of the NHS Constitution targets (year to date) apart from Ambulance R1 and R2. There has been an deterioration in a number of the targets in quarter 3 and *Appendix C* provides more detail on the reasons for the deterioration, the key actions being taken now, with providers, to address the performance and what performance we expect for 2015/16.

BCF level of ambition for reducing NEL admissions

Fundamentally, we believe that the Better Care Fund should be used for genuine transformation of the health and social care system in North Kent, not to plug a gap in the social care or health budgets brought about by increasing demand and reducing budgets. This transformation is not just about reducing admissions to hospital, but rather about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary/community/mental health/social care, with the goal of living as independently as possible. DGS, along with the other 6 Kent based CCGs, has been awarded Pioneer status with Kent County Council - one of 14 Pioneer sites in the country. The Kent Better Care Fund (BCF) Plan has been approved and all conditions have now been satisfied. The North Kent submission has been noted as an area of good practice based on the success and degree of integrated working to date. The Integrated Discharge Team (IDT) within DGS has, for example, attracted national interest. This team, commissioned by the CCG and led by the Trust, brings together primary care, acute, community, mental health and social care professionals with the voluntary sector to focus on facilitated

assessment, treatment and early supported discharge for the elderly frail, patients with mental health needs and those with long term conditions

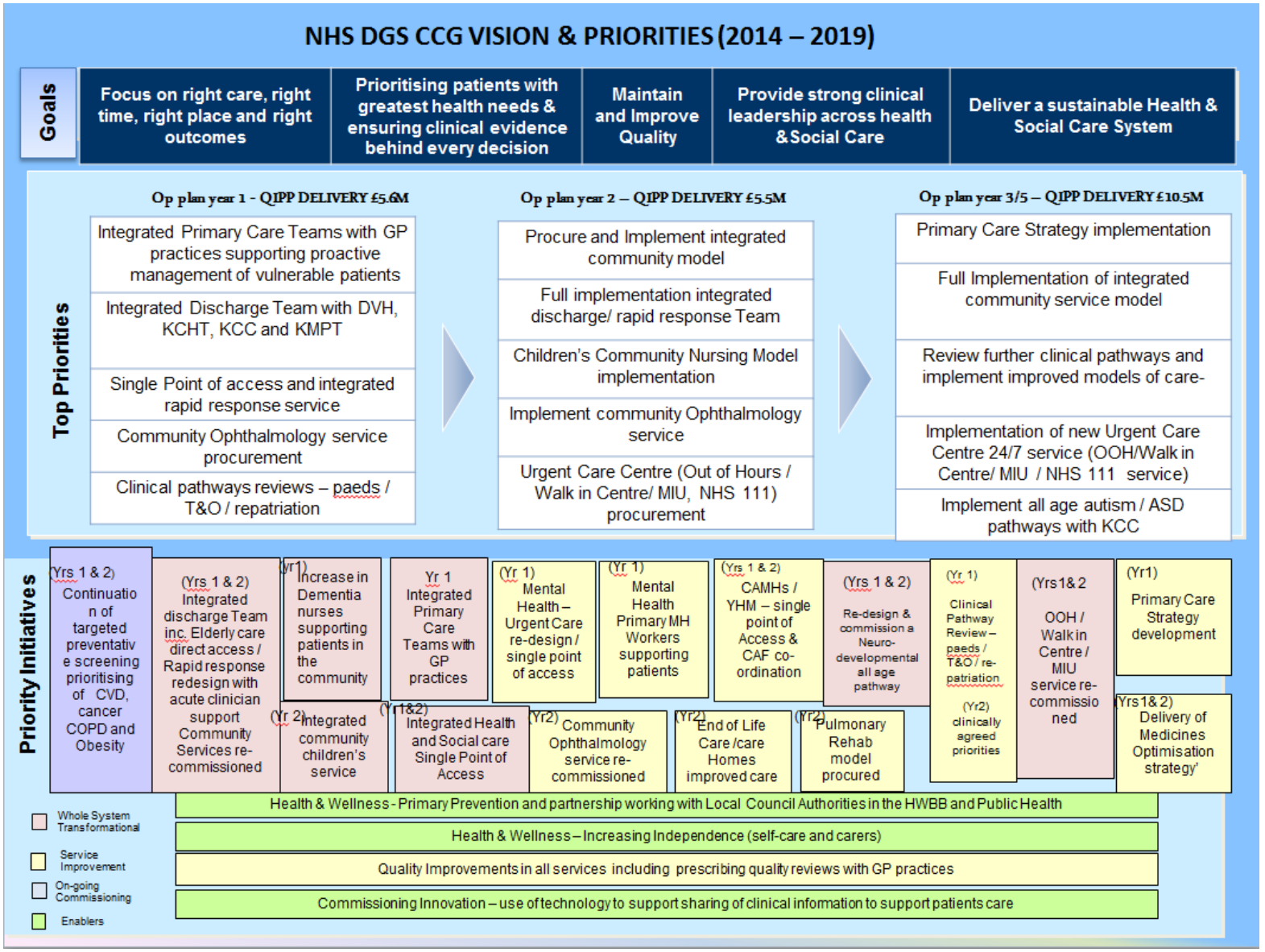
The Kent HWBB have agreed with all Kent based CCGs that the original ambition of 3.5% reduction in NEL admissions is not achievable due to the current significant demand on the acute system and DGS CCG has agreed a 0.8% NEL admission reduction target as part of the BCF (*Reference: DGS Strategic Commissioning strategy for BCF investment)*

Overview of CCG's internal operating plan assurance process

The CCG has developed a clear governance structure for the review and development of whole system, health economy plans. The Executive Programme Board Structure, for example, was developed for this purpose and this links into to a wider governance structure that supports the operationalisation of agreed plans. CCG plans and provider plans are coterminous. All providers have been equal partners in the redesign, which was jointly commissioned through the Kings Fund and Oaks Group and through the development of the Better Care Fund plans.

Providers' 5 year plans are, therefore, a reflection of this joint process. An example of this is the Darenth Valley Hospital Trust Clinical Strategy. The Trust has, since the CCG inception, focused on coterminous clinical relationships with GP's both through the CCG Board leadership structure and directly with Member practices. This has resulted in the establishment of joint governance structures including the clinical interface group, which reports directly into the CCG and Trust Boards. This group drives clinical innovation, reviews respective plans for delivery and has been fundamental in the design and introduction of care pathways and the development of the Integrated Discharge Team and community based Integrated Primary Care Teams around general practice. This joint acute and primary care group is currently focusing on workforce redesign, joint learning opportunities and joint employment opportunities by bringing together the Trust's internal medical education training leaders with local GP trainers. The operating plan describes fully our CCG Governance processes

Appendix A DGS CCG Plan on a Page 2014/16



Appendix B – Details of the QIPP key projects

QIPP Programme Area	Point of Delivery impacted	Sum of 15/16 Planned Activity Changes	Sum of Planned Finance Reduction 15/16	Key Projects
Integrated Care - Dementia and carers	Accident and Emergency	(180)	(24,590)	ADSS Bridging Service Carers short breaks supporting admission avoidance ICES re-procurement (Community Equipment) Primary Care memory assessment service
	Block - community	(300)	(22,905)	
	Contacts - community		0	
	Long Stay Emergency Admission	(166)	(514,016)	
	Long Stay Emergency Excess bed days	(866)	(226,160)	
	Short Stay Emergency Admission	(40)	(39,600)	
Total		**(1,552)**	**(827,271)**	
Mental Health	Accident and Emergency	(100)	(11,700)	All Age Neurodevelopmental Pathway Eating Disorder Pathway Redesign Emotional Wellbeing model for CHYPS IAPT Liaison Psychiatry Peer Support Group Perinatal Mental Health Primary Care and Wellbeing Service development Primary Care Mental Health Specialists Street Triage Peer Support Group
	Block - community	(29)	(191,440)	
	Contacts - community		(250,000)	
	Short Stay Emergency Admission	(360)	(201,667)	
	(blank) Investment	0	50,000	
	BLOCK		(780,000)	
	Peer Support Group - investment	0	15,000	
Mental Health Total		**(489)**	**(1,369,807)**	
Planned Care	Contacts - community		515,425	New to Follow-up ratio - achievement of K&M best practice GP Variation Project Roll out of telephone follow-up appointments in outpatients Procurement of North Kent Community Dermatology Service Procurement of North Kent Community Ophthalmology Service Pain Management Lung Cancer Diagnostic Pathway Direct listing for Endoscopy Skilled Primary Care Surgery potential expansion Development of IBS Treatment Pathway Improved early diagnosis rates in Cancer through various projects / schemes
	Outpatient First Outpatient Procedure		(34,935)	
	Outpatient First Single Professional	(1,502)	(223,776)	
	Outpatient Follow-up Non Face to Face	1,611	38,433	
	Outpatient Follow-up Single Professional	(4,867)	(786,850)	
	BLOCK		(250,000)	
Planned Care Total		**(4,758)**	**(741,703)**	

Prescribing	(blank)		(1,000,000)	**Key projects and milestones:** Quality Work with practices on reducing medicines waste providing a focus on polypharmacy and de prescribing of medicines of limited use or benefit. Ensure appropriate use of Primary care Antibiotic policy to reduce antibiotic resistance Innovation Monitor the CCG impact of new technologies e.g New Oral Anticoagulation drugs, Lubipristone, Nalmefene Productivity Reviewing appropriatnes and cost effective use of specific drugs Prevention Review patients currently diagnosed with hypertension to optimise treatment, Ensure untreated patients are reviewed and prescribed antihypertensives when clinically appropriate Optimise treatment of patients with Atrial Fibrilation with view to stopping the prescribing of Aspirin in line with NICE CG
Prescribing Total			**(1,000,000)**	
Primary Care	Long Stay Emergency Admission	(67)	(168,417)	Health Inequalities - early diagnosis of cancer Health Inequalities - reduction in alcohol related admissions Impact of Integrated Primary Care Teams Increase in public health promotion and awareness to support better self management of conditions Review of all Health Inequalities data to work up and develop in-year initiatives Working with KCC to develop physical inactivity pilot, outdoor gym schemes and health trainer expansion to directly impact hypertension, obesity and diabetes
Urgent Care	Accident and Emergency	(95)	(11,115)	Continue the Integrated Admissions Avoidance and Discharge Team based at daren't valley Hospital , and in the community. The Integrated Primary care teams were launched in Nov 2014. Phase 2 will commence in 2015, and will include specialist palliative care teams. Urgent and emergency care redesign Admission avoidance pilot with targeted care homes and Telemedicine solutions, A new wound management centre pilot and the reinstatement of the EOLC case management Specific long term conditions, such as Diabetes and COPD will be the focus of projects aimed at improving access to education, reducing readmission rates and a reduction in the increase of amputations
	Long Stay Emergency Admission	(282)	(923,332)	
	Long Stay Emergency Excess bed days	(726)	(180,741)	
	Short Stay Emergency Admission	(20)	(15,400)	
	(blank)	(49)	(12,250)	
Urgent Care Total		**(1,173)**	**(1,142,838)**	
Other Investment	Contacts - community		(250,000)	Reducing CHC placement costs
Other Investment Total			**(250,000)**	
Grand Total		**(8,039)**	**(5,500,036)**	

Appendix C – NHS DGS CCG Constitutional Performance and actions

A&E 4 Hour wait	
Current position	The current year to date performance is 95.20% and 94.5% for quarter 3.
Diagnosis	Whilst Dartford and Gravesham NHS Trust failed the four hour wait target in quarter 3 of 2014/15 it has consistently performed better than its peers in Kent and Medway over the recent period. Indeed the latest SITREP as at 8th February 2015 shows D&G as achieving the 8th highest rate of any provider in the country. It is expected that the Trust will sustain achievement of this standard through to the end of the 2014/15 financial year.
Action	Oversight and challenge of the performance is undertaken by on a weekly Programme Management Office approach and through the North Kent Executive Programme Board (EPB) which has agreed key schemes as part of Operational Resilience and associated funding. Funding will cease in March 2014/15 and new ORCP funding for 2015/16 is currently being prioritised to continue supporting reinvestment in the Integrated Discharge Team scheme.
Trajectory for 15/16	The CCG is planning that the A&E 4 hour wait target will be achieved in 15/16
Investment	The ORCP funding within our baseline will be provided to support the continuation of the IDT.

18 week referral to treatment (RTT)for admitted pathways	
Current position	DGS CCG is currently fractionally below the 90% standard for admitted referral to treatment times on a year to date basis (89.95%). Early indications are the CCGs performance for December is ; Admitted 92.4%, Non-Admitted 97% and Incomplete Pathways95%, meeting all standards. With the exception in Quarter 2, the target has been achieved in all other quarters in the financial year.
Diagnosis	The CCG would be achieving the standard, but for the national additional RTT activity initiative which ran from July to November 2015. This initiative encouraged and funded providers to explicitly target their backlog patients in order to help sustain the RTT target going forwards. This resulted in a significant dip in performance for DGS CCG, at Dartford and Gravesham NHS Trust driven by the specialties that were part of the national initiative (84.49% August 2015).
Action	We are working closely with our local acute provider, and a number of outpatient specialities have introduced telephone follow up to reduce the need for patients to travel to the hospital and ensures more efficient use of hospital resources. Due to the success of this development (from the patient perspective, the Trust perspective and the CCG perspective) the CCG is working with the Trust to expand this to more specialities in 15/16. This will ensure that we have improved capacity for RTT.
Trajectory for 15/16	Compliance with the standard
Investment	None

Ambulance Cat A Red 1 and Red 2	
Current position	For 2014/15 it is expected that the Red 1 target will be met, but Red 2 will marginally fail at over 74% achievement for the full year although it has achieved in each month since October 2015, with the exception of December and performance should be maintained through the remainder of the financial year and into 2015/16. This standard is reported at a Kent and Medway level.
Diagnosis	Hospital pressures continue to be the major problem for SECAmb in terms of the hours lost from crews waiting at hospitals. DVH has reduced the number of hand-over delays in the last few months the
Action	As part of the revised system improvement plan trajectories have been agreed for eliminating over 60 minute handovers, improving the number of handovers within 30 minutes and reducing the number of hours lost from crews waiting at the hospital. There is evidence that the planned schemes in DVH are starting to positively impact and there has been an improvement in the local SECAmb response times as the ambulance crews are released back on the road much sooner. Further improvements are required.
Trajectory for 15/16	The CCG is planning that Red 1 and 2 targets will be achieved in 2015/16. This will be further supported by a continued focus on handover performance through the DVH contract.
Investment	No specific investment. Contract negotiations focusing on totality of activity.

Cancer Access Targets	
Current position	• **Cancer 31 day subsequent treatment (Radiotherapy)** – performance for the year to date (to dec) is 94.77% and 92.19% for quarter 3 • **Cancer - 62 day urgent referral to first** treatment - performance for the year to date is 86.09% and for quarter 3 it is 83.76% • **Cancer 62 day screening referral to first treatment** - performance for the year to date is 93.33% and for quarter 3 it is 88%
Diagnosis	In December, the CCG did not meet the standard for 31 days wait for a second or subsequent treatment (radiotherapy). 42 out of 46 patients were treated within 31 days. The reasons for breaching were all patient choice.
Action	Currently year to date the Trust is achieving the Cancer targets and we intend to continue to monitor this constitutional target at monthly performance and contracting meetings
Trajectory for 15/16	The cancer targets will be achieved in 2015/16

Appendix D – Programme Summaries

Programme Area: Urgent Care and Long Term Conditions

Objective:
To achieve a reduction in numbers of A&E attendances, non-elective admissions and excess bed days, reduce numbers of patients who remain in hospital when medically stable, and sustainably meet the 4hr A&E target. The work will have a specific focus on pathways for complex elderly/patients with long term conditions, enabling them to manage their conditions better, maintain independence and quality of life, and ensure care is provided in the most clinically appropriate setting.

Key Drivers for Change:
The Keogh report and the 5 year forward view highlight the need for better integration of urgent care service provision including links to primary care in order to reduce demand on A&E departments
Growth in the elderly population and therefore LTCs will increase pressures on A&E and hospital beds. Performance against 4hr A&E target regularly comes under pressure and large number of patients are "medically stable" but not discharged from hospital. Oaks Group capacity work supports initiatives for patients to be looked after with support in community thus avoiding deterioration and resultant hospital admission, and for patients to be discharged with support to community.
This requires better identification of people artrisk of hospital admission, and integrated care plans shared and actioned across health and social care
COPD readmission rates have increased significantly. In addition prevalence of Type 2 Diabetes is increasing in line with national trends Many Diabetes patients remain undiagnosed and many have never taken up any form of structured Diabetes education.
Deaths in hospital remain high in DGS despite the majority of patients expressing their preference to die at home, and not enough patients have comprehensive care plans in place reflecting how they wish to be cared for as they approach end of life

What did our providers and GPs tell us?

Issues flagged from acute, community and primary care providers include problems for GPs in making urgent care referrals, and delays in discharging patients once admitted to hospital, particularly for patients who need to move to residential accommodation, or who need additional support to return home. Providers also highlight that many people continue to attend A&E unnecessarily.

What did our patients and local population tell us?

Focus group work shows patients want:
Clearer signposting of services for LTCs and alternatives to hospital,
Clarity on what services are available including out of hours.
Improved access to primary care services.
Recent survey shows those attending A&E have less knowledge of services outside of hospital, and are less likely to use them in future than the general population.

Key projects:
Continuation of the Integrated Admissions Avoidance and Discharge Team (IDT) based at DVH , and in the community, improving links to IMPACT and rapid response, and signposting to other services.
Evidencing impact of the IDT will be supported by a **proposed transactional change in tariff payment** for patients who are admitted to an observation area at DVH whilst the IDT work on alternative to admission to a ward. This is currently charged at same rate as a full admission.
In response to the Keogh review, **the urgent and emergency care redesign programme** has commenced, jointly with Swale and Medway CCGs. This will review the current A&E depts, MIU, OOH and walk-in centre activity, resulting in proposal of a new model of care. Milestones :
Draft specification and business case complete by July 2015
Public consultation July-October 2015
Procurement process November 2015 – Autumn 2016
New services to commence Autumn 2016
Reduce variation in urgent care activity between GP practices - review urgent care activity by practice in order to understand and address variations in attendances and admissions; this project will be developed during first quarter of 2015/16, linked to analysis of planned care activity
Improving care coordination at end of life to ultimately reduce deaths in hospital: the development of an electronic palliative care coordination system (EPaCCs) which will be designed within Vision 360, the increase of GP palliative care lists, and targeting outlier practices with high hospital death rates.
A variety of projects to reduce falls including identification and support for those at risk of falls, support to care homes, falls pathways development and improved referrals to postural stability classes
Improved use of alternative pathways for patients with LTCs and improved utilisation of specialist nurses to avoid unnecessary ambulance conveyances.
Revision of diabetes LES to improve management of patients in primary care and reduce variation in outomes
Weekend provision of diabetes education to improve self-care
Other projects that will impact urgent care activity or underpin delivery :
Dementia ADSS bridging service and Crossroads carers support service
Integrated primary care teams
Extended liaison psychiatry service at DVH from 5pm - midnight
Re-procurement of the integrated community equipment service
Re-procurement of community services contract
DVH frail elderly pathway development

Programme Area: Urgent Care and Long Term Conditions

Risks and mitigating actions

The IDT and related services are currenty funded on a non-recurrent basis via winter escalation money , therefore the sustainability of these services going forward will need to be built into contracting arrangements.

Commissioning plans to deliver changes in urgent care activity will be dependent on changes in behaviour of patients. The urgent care redesign programme includes extensive patient and public engagement from initial design of preferred service model to implementation.

Risks identified that may result in non-delivery of commissioning plans are entered on the CCG corporate risk register which is reviewed on an on-going basis by the Governing Body.

Workforce implications:

Provider workforces have been increased considerably via winter funding. Commitment has been made that where skills shortages exist, recruitment would be on permanent basis at risk to overall health system.

Workforce implications of the urgent and emergency care redesign programme will be addressed within the overall governance structure

Resource implications 2014/15:

Total planned net savings : £1,732,162

A&E attendance reductions from dementia carers support, improved use of alternative pathways, falls and reducing variation in urgent care activity between practices

Excess bed day reductions from IDT, dementia bridging and carer support services

Non elective admission (short and long stay) reductions from IDT, IPCT, falls, dementia bridging and carer support services, and liaison psychiatry

The urgent and emergency care redesign programme will not impact activity until 2016/17

KPIs (link to national KPIs):

Achievement of all national indicators in relation to urgent care, including 4 hour A&E waiting time, ambulance response targets and handover times

Reduction in non-elective admissions for targeted groups of patients

Reducing time spent in hospital after patients are medically stable (using excess bed days as proxy)

Reductions in emergency readmissions for targeted groups of patients

Increase in number of patients discharged from acute or community hospital to normal place of residence

Increase in number of people reviewed by IDT, and of those, increase in those discharged to usual place of residence

Improved use of alternative pathways

Additional KPIs are being developed for 2015/2016 commissioning plans

Programme Area: Planned Care and Cancer

Objective:
The CCG aims to ensure that all patients have access to a wide range of high quality services, and can be seen quickly by the most appropriate clinician in a location as close as possible to their home. With a variety of alternative pathways where clinically appropriate to enable choice; the best possible use of limited acute hospital capacity and contributes to ensuring that patients' rights under the NHS Constitution to be treated within a maximum of 18 weeks from GP referral are achieved.

Key Drivers for Change:
Services commissioned by the CCG need to be responsive to the needs and expectations of patients, taking into consideration any potential health inequalities in the system, with a strong focus on quality of care. With a large and growing elderly population, patients with multiple conditions will often be seen by a number of clinicians, and it is vital that appropriate links are fostered between these clinicians to provide a seamless integrated service for patients that is responsive to their needs. As part of this, the CCG is working with local providers to ensure that as much hospital-based activity as possible can be provided locally, to minimise both travel for patients and disjointed clinical care.

What did our providers and GPs tell us?
All projects within planned care have a lead GP involved throughout their development, and are also influenced by the views of member practices, this ensures that initiatives developed by the CCG are truly clinically led and responsive to the needs of local patients.
The CCG also works closely with its providers (particularly Darent Valley Hospital and Kent Community Healthcare Trust) to jointly re-design pathways and improve services. This enables us to respond to trends that are observed by providers, including the publication of referral guidance for GPs to prevent unnecessary referrals.

What did our patients and local population tell us?
Patients have told us that they would like to see a full range of truly integrated services available locally and appropriate signposting to other available services relevant to their condition. Patients see their GP as the person who should hold the ring on all of their health needs, and for that reason the CCG ensures that all of our GPs are aware of the full range of services available. Patients would also generally prefer to be treated locally rather than having to travel long distances to access services.

Key projects and milestones:
Schemes expected to impact in 2015/16:
Achievement of contractual best practice new to follow-up ratio at Dartford and Gravesham NHS Trust ***[Overall potential saving -£1,642,369]***
GP Variation Project – Proposed project to reduce variation in GP referral activity in order to reduce acute activity. Note: This is a very new idea in the scoping phase, but initial thoughts to undertake some in-practice comparisons between GP referral behaviour in appropriate specialty areas and / or comparison between practices of similar size / population / geography to identify areas of further GP education / upskilling which DVH consultants / clinicians are keen to support. Utilisation of locality meetings for some of this work.
Roll-out of telephone follow-up appointments in additional specialties (list) due to increased utilisation and efficacy of this service development from 2014/15. This will ensure appropriate utilisation of limited outpatient capacity and provide greater convenience for patients whilst guaranteeing the same input from a hospital consultant. ***[Overall potential saving - £162,210]***
Procurement of NK Community Dermatology Service – expected shift of 70% activity and cost from secondary care into the community within a local tariff structure (with predicted overall savings of 5%). ***[Overall predicted saving - £35,966]***
Procurement of NK Community Ophthalmology Service – expected reduction in secondary care activity and cost TBC
Pain Management – More focussed work on development on psychological pain management provision with opportunity to embed some provision within the revised service spec for IAPT contracts – to be re-procured Aug 15. Also focus on self-management schemes for patients initiated in primary care. Financial savings TBC although impact likely to be longer term and not necessarily seen in-year.
Lung Cancer diagnostic pathway – proposed pilot scheme to enable GP's to have direct access to CT in order to ensure 2ww referrals actually have a likely diagnosis of lung cancer. Will also support the early diagnosis and reduction in mortality highlighted within the CCG 5-yr strategy.
Direct access endoscopy – DVH already initiated 'one stop' endoscopy triage – i.e. if quality referral received by Gastroenterology that can be triaged by consultant as 'direct for endoscopy' this diagnostic will be booked in straight away without the need for an initial consultant appointment. Aim to increase awareness of this service, with GP education offered by DVH to improve quality of referrals to enable this where clinically appropriate. Reduction in 1st OP att.
Re-procurement of skilled primary care surgery – depending on outcome of RFI process this service may need to be re-procured in accordance with procurement law and agreement at Clinical Cabinet. Potential to reduce secondary care activity (1st OP att) if outcome of re-procurement results in more activity shifting to primary care.
IBS Treatment pathway – NICE guidelines due to be published March 15 and Kent-wide agreement required for IBS treatment pathway (particularly around prescribing of probiotics). Potential to launch IBS treatment pathway (to align with DGS IBS Diagnostic Pathway already in place) later in 2015-16.
Improved early diagnosis rates in Cancer and better utilisation of the 2ww pathway – through NK GP education event to be held in January 2015, and continues review of GP access to diagnostics to improve quality of referrals. This is a national driver supported by the SCN and NHSE. This may not result in a financial saving but is a must-do for all CCG's in terms of quality of care and improving outcomes for Cancer patients.
Integrated Community Equipment Service Re-Procurement – Kent-wide review has been undertaken in the last year to go ahead with re-procurement process from Jan 15. New service to be mobilised by September 2015 under current timeline.
Reviews to commence in 2015/16 with impact expected in 2016/17 dependent on outcome of reviews:
Review of continence services both for Gynaecology and Urology patients with a view to increasing community provision for this activity, thus reducing secondary care activity. As yet unclear whether this will be a Planned Care project or part of the overall Community Services Redesign work. Joint working with Medicine's Optimisation will be essential due to high prescribing spend.
Scoping of other Gastroenterology projects / conditions where further GP education could reduce unnecessary secondary care activity. This is an area DVH are keen to work together on.
Scoping of Rheumatology pathways and services – DVH currently scoping possibility of bringing Rheumatology back in-house from MFT as an MSK service that sits under the Orthopaedic Directorate. Opportunities to therefore review rheumatology pathways – particularly around GP direct access to diagnostics – e.g. CCP antibodies

Programme Area: Planned Care and Cancer

Risks and mitigating actions:
Delivery of all commissioning intentions will be closely monitored on a monthly basis and mitigating actions identified to address any non-delivery.
Any risks identified that may result in non-delivery are entered on the CCG corporate risk register which is reviewed on an on-going basis by the Governing Body.

Workforce implications:
The aim of all commissioning intentions in planned care is to make the best possible use of limited clinical resources, both in primary and secondary care. The aim at all times is to ensure that patients are signposted to the right place and the right clinician at the right time, with quality of care being the primary focus.
The overall impact on primary care will be considered as part of the Primary Care Strategy currently in development.

Resource implications:
2015/16:
Planned net savings £TBC
New outpatients reduction – from GP variation project, Dermatology re-procurement, Respiratory (due to Lung Cancer diagnostic pathway change), Community Ophthalmology re-procurement and Direct access Endoscopy.
Follow up OP reduction – from roll-out of telephone follow-up appointments, Dermatology re-procurement, Community Ophthalmology re-procurement
Increase in non- face to face follow up outpatient appointments – from roll-out of telephone follow-up appointments

KPIs (link to national KPIs)
NHS Outcomes Framework:
Reducing premature mortality from the major causes of death – includes a number of cancer outcomes
Delivery of NHS Constitution Access Targets – cancer waiting times and referral to treatment
Improving outcomes from planned treatments
Improving people's experience of outpatient care

Programme Area: Promoting Wellbeing and Mental Health

Objective:
There is an ageing population and increased prevalence of chronic diseases that requires health services to move from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated.
Over the next two years the CCG are focusing on developing mental health services within the community and primary care settings. The purpose of this being to increase identification and management of adult mental health conditions in primary care, including where this is secondary to a physical long term health condition. This is also to ensure patients get to the right mental health service, sooner and in a setting closer to home.

Key Drivers for Change:
It is reported that one in four people in England and Wales will have some form of mental illness over their lifetime
Mental Health accounts for nearly 40% of morbidity
The impact of mental health affects all sectors e.g. education, social, health, criminal justice system etc. increasing necessity for integrated services that are accessible and placed in a variety of settings.
Among people under 65, nearly half of all ill health is related to mental illness

What did our providers and GPs tell us?
Some of the areas highlighted as key to successful service delivery include:
Partnership working, Ensuring communication between clinicians
Patient owned recovery
Improved OOH access and awareness of OOH services available
Tools to support GPs in diagnosis and education/ training for GPs and practice staff
Timely access to specialist diagnostic opinion
Clear pathways

What did our patients and local population tell us?
Further development of dual diagnosis services in primary care (mental health/substance misuse)
Further strengthen links between health and social care – integration of services for older adults
The need for secondary care services to have a greater awareness and understanding of resources and services available in primary care and more services available locally
Development of early intervention services in primary care
More services specifically aimed at children and young people in primary care
Further work to raise awareness and reduce the stigma of mental health issues
Improve/raise standards and quality of primary care services

Key projects and milestones:
IAPT – The Improving Access to Talking Therapies service is available to people experiencing mental distress in relation to common mental health problems. In 2015-16 this service is continuing and will continue to contribute to expected outcomes.
Primary Care Mental Health Specialists – This service is continuing in 2015-16 . The current view is that the vision for a Community Mental Health and Wellbeing service will encompass this service model.
Continuation of the Primary Care Community Link Worker project - this service is continuing in 2015-16 . The Community Mental Health Wellbeing service will encompass this service model, the service is funded jointly with Kent County Council.
Neurodevelopmental Pathway – this project is located in the Integrated Commissioning programme summary. Service redeisgn encompasses transformation of ADHD & ASD services by procuring an all age care pathway to go live in 2016-17.
Personality Disorder Peer Support Group – The peer support group will continue in 2015-16 to provide a local service on patients who frequently attend a range of services, linking with KMPT commissioned services and a wide range of community services to enhance wellbeing of health.
New for 2015-16: - 18+ Community Mental Health and Wellbeing Service development in partnership with Kent County Council
New for 2015-16: - 0-25 Emotional and Wellbeing Service in partnership with Kent County Council
New for 2015-16: - Secondary mental health services continued transformation of urgent response services. The introduction of a Single Point of Access was implemented as Phase 1 in 2014-15.
New for 2015-16: - Review of all age Eating Disorders services against population need and demand to determine if current provision is appropriate for expected outcomes.
New for 2015-16: Liaison Psychiatry Service development - possible enhanced scope of service to focus on patient presenting with medically unexplained symptoms.
New for 2015-16: Perinatal Mental Health - review of current service provision within CCG commissioned services and Public Health services, reviewing needs assesment and current activity.
New for 2015-16: Street Triage service development in line with Crisis Care Concordat

Programme Area: Promoting Wellbeing and Mental Health

Risks and mitigating actions:

Risk that identified population need to enter talking therapies will not be met. Actions include continuous engagement with GPs and local community services, working with providers to ensure services are advertised appropriately and engaged with other services. Advertisement on Live it Well website to encourage self referral and enhance patient choice. Activity monitored through the local contracting and performance groups.

It is likely that the expected outcomes of the Emotional Wellbeing Strategy will not be realised until 2016-17 and beyond. If the early intervention outcomes are realised, the benefit is long term in reducing the number of patients with co-morbidities and poor mental health later in life.

GP practices have limited capacity and therefore support available is being enhanced in 2015-16 to manage demand and support GP practices without placing unnecessary pressure on practices.

Delivery against Crisis Concordat declaration. Overarching steering group in place with signed up representation from agencies focusing on mental health crisis care and subgroups in place to deliver actions against four key aspects of concordat. A Kent wide action place will be uploaded to the national website by the end of March 2015.

Workforce implications:

KMPT secondary mental health services - requirement for services to be aligned appropriately in order to deliver outcomes linked with commissioned services.

Resource implications:

2014/15:

Achieved net savings £80,370

2015/16:

Planned net savings £354,807k

KPIs (including link to national KPIs):

Increase adult access to talking therapies and ensure recovery rates at met

Enhance quality of life for people with long term conditions

Proportion of people feeling supported to manage their condition

Improving people's experience of integrated care

Additional for 2015-16:

- Access to support before crisis point
- Recovery and staying well

Programme Area: Integrated Commissioning - Dementia / LD

Objective:
To transform the current service provision for people with dementia and develop a redesigned integrated pathway where dementia, depression and anxiety are treated under the long term condition model of care and a person's needs are treated holistically factoring in physical and mental health needs together.
Deliver more care closer to home by increasing the availability of expertise for assessment, treatment and on-going support for people with dementia and common mental health problems in the community.
Enhancing the mental health capacity within primary and community care should stimulate referrals for diagnosis and increase the overall diagnosis rate.
Reduce non-elective admissions and excess bed days, focussing pathways for complex elderly/patients with LTCs
Deliver improved quality and value within current services and investment to reduce the inequalities in accessing all health services and health outcomes, including premature death, experienced by people with Learning Disabilities.
Implement and monitor Joint Strategic Winterbourne plan with KCC.

Key Drivers for Change:

The current pathway of care for people with dementia is fragmented with a need for improved support in the early stage of dementia.
Increasing number of people with dementia admitted to the Acute Hospitals that are not known to current services and these people historically have long lengths of stay and end up in premature long term care placements.
Diagnosis rates are still below the national expectation to deliver a 66% diagnosis rate by 2015 and continued improvement in 2015/16.
There are excessive waiting times for people with autism, being addressed through Neurodevelopmental pathway.

What did our providers and GPs tell us?

GPs want a clear and concise pathway for assessment and diagnosis that is achieved in a timely manner and mental health nurses within the community that can support people post diagnosis.
Providers are unable to meet the current influx for memory assessment due to the increase in referrals for assessment and are co-developing the revised

What did our patients and local population tell us?

They want a rapid diagnosis, good clear information and signposting and a range of support post diagnosis. Carers want support and respite to help them manage the burden of caring for someone with dementia.

Key projects and milestones:

A range of projects with focus on appropriate admissions management of patients and timely discharge to ensure the best possible outcomes are achieved through timely access to a range of community based health and social care services.
Assessment and diagnosis pathway for dementia – enabling earlier diagnosis.Continue to implement Mental Health Nurses in Integrated Primary Care Teams to safely and effectively manage dementia assessments and the coordination of care pre and post diagnosis
Develop and enable clear pathways of care and support for people with dementia and their carers to Voluntary Sector organisations within each locality.
Expand the range of jointly commissioned Carers services to provide Carers Short Breaks, crisis intervention and support hospital discharge.
Develop the capacity and capability of primary care staff including receptionists and health care assistants by establishing a foundation level dementia awareness training programme within each locality.
Winterbourne – Fully implement and monitor effectiveness of new integrated care pathway with enhanced community support. Continue to discharge patients in line with their care and treatment reviews.
Expand the range of community based LD services (Statutory and Private/Voluntary sector) to meet needs of individuals discharged from hospital and reduce numbers being admitted; and improving Quality of care for people with Learning Disabilities.
Integrated Learning Disability Commissioning – Work with KCC and other Kent CCGs to develop a Kent wide integrated approach to commissioning learning disability services as recommended in the BUBB report using the governance arrangements for the Better Care plan.
All age neurodevelopmental pathway for Autism and ADHD. Transformation of Autism and ADHD services by procuring an all age neurodevelopmental care pathway. This work is being scoped Kent and Medway wide with a view to procurement in 2016/7.

Programme Area: Integrated Commissioning - Dementia / LD

Risks and mitigating actions:
People with dementia will continue to enter the care system in crisis leading to inappropriate admissions, long lengths of stay and carer breakdown.
Mitigating actions: Further develop the Integrated Primary Care Teams to identify people with dementia at high risk of admission or carer breakdown and provide active case management to support at home.
Enhance post diagnostic support and direct referral pathways to voluntary sector organisations.
Future modelling of local tariffs for MH PbR identifies that post diagnostic support does not carry a high tariff and it would be disadvantageous to contract with an alternative provider.
On-going monitoring of activity for admissions to Acute Hospitals to identify other areas for dis-investment

Workforce implications:
Historically high vacancy rates in key teams may impact on service delivery.
Will require a higher degree of flexibilty within current work regimes.

Resource implications:

2015/16
Planned net savings: £827,271k

KPIs (link to national KPIs)
67% diagnosis rate for dementia by 2015/16 with continued improvement throughout 2015/16.
Reducing time spent in hospital by people with long term conditions
Reduction in emergency admissions for conditions that shouldn't normally require admission
Helping older people to recover their independence after illness or injury
The NHS Outcomes Framework also has an aim to ensure people with dementia received timely diagnosis and receive the best available treatment and care
The recent NHS Call to Action, requests CCGs to transform pathways of care to achieve early diagnosis so that effective care planning can be put in place

Programme Area: Children and Young People

Objective:
Promotion of personalisation and patient centred care
Reduction in A&E attendances and NEL emergency admissions.
Deliver care closer to home through a hospital at home approach
Alignment with the CCG's wider transformation programme on urgent care for adults.
Delivery of the Healthy child programme
Reduce health inequalities and improve health outcomes of children and their families through promoting early identification and prevention models
Implement the new statutory duties and powers within the Children & Families Act 2014
Commission local services to enable children and young people to remain in their local communities

Key Drivers for Change:
The implementation of these commissioning intentions will contribute to:
A new multi-agency whole system approach to meeting the assessed needs of children, young people and their families through stronger community based provision, delivered through new approaches to joint commissioning with Kent County Council and Schools and Colleges.
Roll out person health budgets.
Roll out of the new 0-25 Education Health and Care Plans for children and young people with Special Educational Needs.
Need for increased understanding of the child's and family's needs.
Need for effective transitions at all key life stages including transition to adult services.
Reduce escalation of child's challenging behaviour, family breakdown, self-harm, suicide risk and the need for high cost out of county placements.
Reduction in Tier 3 CAMHS usage.
Care is offered as close to home as possible to enable children and young people to actively participate in educational and community based activities.
Reduction in avoidable admissions for Lower Respiratory Tract infections and for asthma, diabetes and epilepsy for under 19's
Promoting self-care and increased confidence amongst children and young people to manage their condition.

What did our providers and GPs tell us?
Successful delivery can be achieved through adopting:
A common approach to integrated working across health, education and social care.
A multi-agency to early intervention and prevention
New multi-agency approaches to workforce training and development to promote early identification, intervention and improved standards of care.
New primary care led models of care to improve communication and joint working.

What did our patients and local population tell us?
Families tell us that they want to tell their story only once, have integrated services that are responsive to the child's needs, close to home and with caring staff who know the child and their needs.
CCG led patient and public engagement events confirmed that there was a desire amongst members of the public to have an increase in community based services nearer to where they live and fewer hospital based services.

Key projects and milestones:
Review and improve the outcomes for children and young people with speech language and communication needs and children and young people with a physical impairment. This could include additional investment in specialist SaLT, OT and/or physiotherapy to support specific care pathways, will promote joint commissioning with KCC, and the delivery of the Kent Local Offer for children and young people with SEN (special educational needs) or those who are disabled to enable compliance with the new joint commissioning duties as detailed in the Children and Families Act 2014.
Challenging Behaviour - Enhance the specialist input provided at an earlier stage to prevent breakdown of the family support network for children with a learning disability, autism spectrum disorder and/or mental health condition and therefore prevent/reduce out of area placements. This enhancement will need to be aligned to the new, and developing, all age neurodevelopmental pathway.
Urgent and Emergency Care – Develop and implement a whole system approach for urgent and emergency care for children and young people including a hospital at home element to a new community children's nursing service model. This will include a review of the transition pathways for children with long term conditions, disabilities and complex continuing care conditions. This service will offer care closer to home and promote closer integration between primary care, community based services, local and tertiary acute providers.
Community Paediatrics – A whole community paediatrics service review, development of a service specification and identification of the different elements of the current block contract services. This will identify the content of the block and tariff parts of the contract and will review the transition pathways to adult services.
The development of a tender process, that procures a Kent and Medway wide service, which provides a standardised and consistent level of service to Looked After Children (LAC) irrespective of where the child is from in Kent or where in Kent they are placed.

Programme Area: Children and Young People

Risks and mitigating actions:

Escalation of children being sent to expensive out of county placements, exclusion from schools, family breakdown, eventual placement in adult services.
Gaps in service of therapies for children with PD. Inability for children to lead independent lives, free of pain, ability to take part in activities and increase in poor health outcomes.
Children not able to communicate, affecting education attainment and social interactions.
Possible escalation into social exclusion, poor behaviour, isolation, crime and inability to gain employment.
Tribunal challenges and costs for CCG resulting from parental dissatisfaction at lack of service for child who has an Educational, Health and Care Plan (EHCP).
Increase in children accessing acute services, year on year increase on A&E attendances
Poor health outcomes for children and young people in care due to failure to provide quality and timely assessments of health needs
Failure for CCG's to meet their Statutory Requirements for Children in Care and those CIC with an adoption plan.
Less integrated working, information sharing, team around the child and family.
Cost pressures for CCG due to increasing use of expensive specialist services
Within the Mandate for the NHS and Everyone Counts it is a priority for NHS England to ensure that personal health budgets are offered as part of an Education Health and Care Plan. The Department of Health have asked CCGs to start the roll out of personal health budgets with children's continuing care and continuing healthcare packages from 1st April 2014.
Lack of choice and flexibility for child and family when choosing care packages

Workforce implications:

The successful delivery of the commissioning intentions will require the implementation of new multi-agency workforce training and development programmes to enable a broad range of professionals to ensure that children's needs are identified early and the right support is offered at the right time, in the right place.
The commissioning intentions will require providers to review the skill mix of existing teams and how specific roles overlap across health, education and social care. This could also include looking at new enhanced roles to deliver specific outcomes e.g. the development of the Advanced Nurse Prescribers.

Resource implications:
2015/16:

Planned net savings to be defined
Activity impacts included in block contract

KPIs (link to national KPIs)

National Outcomes Framework:
Enhance quality of life for people with long term conditions
Proportion of people feeling supported to manage their condition
Improving people's experience of integrated care
'No health without mental health'

Programme Area: Health Inequalities and Primary Care

Objective:
The aim of the Health Inequalities programme is to reduce life expectancy variation and improve the quality of life for local people
Work with those practices which would benefit from additional focus and support to identify and work with patients most at risk of deterioration and potential admission to hospital
- To raise awareness of the causes of key conditions and support preventative programmes and self-management.
- To improve links and provide support for difficult to reach communities.
- To forge closer working relationships and knowledge of the voluntary sector organisations, to help patients and carers to access the support that they need.

Key Drivers for Change:
There are significant health inequalities indicators for DGS, including ill health from preventable diseases and significant difference of life expectancy between the highest and lower quintiles (10 years). DGS is currently within the bottom 20% of most deprived areas. It has a higher than national average of adults with obesity and has high prevalence of hypertension and chronic kidney disease.
The Health Inequalities work is supported by The Health and Social Care Act, the Kent Joint Strategic Needs Assessment and Wellbeing Strategy, as well as the recently published '5 Year Forward View' document. This sets out a vision of a radical upgrade in prevention and public health, to ensure that when people do need health services, patients will have greater control of their own care. It also highlights the need break down the barriers in how care is provided, e.g. between family doctors and hospitals; physical health and mental health and social and health care.

What did our providers and GPs tell us?
GPs have identified the need for improved working with community nursing and social care to provide integrated support for people with long term conditions.
Our Acute Trust Consultants would like to have a closer working relationship with individual GP practices to help improve management of patients to support them better within their home and primary care setting.
Voluntary organisations want to strengthen relationships and knowledge with primary care in order that patients are given information they need to access local voluntary organisations, to help support them with their needs.

What did our patients and local population tell us?
Public engagement events have highlighted the need for more clarity and improved communication in relation to the delivery of support to help people manage their own health
A comprehensive programme of engagement as part of the community services redesign project has identified that patients want to be supported to care for themselves, be able to tell their story once, and have seamless care across health and social care professionals

Key projects and milestones:

Continual review of health inequalities data, via HISbi, across DGS to be undertaken, in order to inform in-year projects/initiatives for 2015/16.
Improved data intelligence supplied to GP practices in order that they understand their local health inequalities status and individual CCG support tailored to meet the needs of that practice, to help increase the identification of patients needing support for their condition. To be conducted in conjunction with the medicines management team practice visits to ensure synergies in optimising patient care and cost effectiveness.
Increase in the health promotion and disease prevention communications to the public via local media.
Supporting practices with their MDT meetings, whereby they regularly review their most at risk patients, with members of the Integrated Primary Care Teams.
Phase 2 roll-out of the Integrated Primary Care Teams, to expand them to include other key providers, including pharmacy, to further support people with long term conditions both in terms of self-management and in the event of a crisis. (Total savings linked to all of the above initiatives -£184k)
Working more closely with KCC regarding current commissioned services to understand the outcomes being achieved, as well as looking at future procurements to ensure that they meet the needs of both the Health and Care Social Care objectives to achieve health benefits.
Closer liaison with KCC regarding health promotion messaging and education within schools.
Develop a Communication and Engagement plan which demonstrates how we will work with the local Asian population to determine the support which can be provided to reduce the prevalence, and increase effective management of diabetes.
Working with KCC to implement a physical inactivity pilot project.
Potential project regarding supporting and maximising the impact of health trainers within the community.
Working with KCC to help promote the 'Outdoor Gym' schemes and be part of the planning regarding their locations.

Programme Area: Health Inequalities and Primary Care

Risks and mitigating actions:
Public engagement activities only reaching the 'already converted', with limited ability to assess effectiveness.
New initiatives that are put in place, may not see health benefits for several years, therefore financial savings will not be realised in the short term.
The success of the communications and engagement work around health promotion messaging will be difficult to quantify.
Many of the initiatives that will be put in place are funded on a non-recurrent with grant money, therefore the sustainability of these services going forward should they be successful, will need to be built into commissioning intentions going forward.
Potential for an increase in prescribing due to more patients being identified as needing medication to help prevent more serious health conditions.

Workforce implications:

A key aspect of this scheme will be linking with existing staff and services, including local authorities, primary care clinicians, community and acute providers and the voluntary sector, to ensure a consistent approach to identifying people with or at risk of developing long term conditions.
Potential to secure 4 sessions per month from a GP with an interest in the health prevention and health inequalities agenda, to help champion this work within general practice.
Potential requirement for additional public health data analyst support to ensure information is collected, analysed and sent out to all relevant stakeholders to help inform the work that needs to be taken forward

Resource and activity implications 2014/15:

Financial savings have not yet been identified for this work programme.

KPIs (link to national KPIs):

KPIs for this programme area are predominantly related to reduction in A&E attendances or admissions which are articulated within the urgent care programme summaries:

- Prevent people from dying prematurely
- Securing additional years of life for the people of England with treatable mental and physical health conditions
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.

Programme Area: Prescribing

Objective:
To support the implementation of quality patient outcomes to drive improvement and efficiency through evidence based cost-effective prescribing across the whole patient pathway, as well as Improving patient understanding and concordance with their medication which is key to medicines optimisation.
Medicines form 13.2% of total DGS budget, plans within this programme area aim to take into consideration improved quality & efficiency savings, which may be used to fund new treatments approved by NICE and improvement in patient pathways.

Key Drivers for Change:
Meeting this objective will place CCG in a position which could be sustainable enough to fund changes needed in whole patient/treatment pathways allowing ease of access to treatments for patients. This would support the needs of the increasing older population in DGS particularly those with LTC

What did our providers and GPs tell us?
To provide support with delivery of DGS Medicines Optimisation QIPP at practice level using appropriate data sources that improve G.P understanding of prescribing with demographic and prevalence data.
To work closer with providers in developing QIPP plans across the local area and so reduce variation of prescribing from one provider to another hence maintaining high quality of care for patients

What did our patients and local population tell us? To reduce variation in prescribing and improve access to treatment in a timely way without compromising quality
To ensure seamless care across interfaces by improving communication between services

Key projects and milestones:

Quality

*Continue with implementation of Benzodiazepine prescribing policy for newly prescribed patients. Undertake supported review of selected cohort of patients at higher prescribing practices.
*Work with practices on polypharmacy to minimise patient risks, improve quality and decrease waste
*Ensure appropriate use of Primary care Antibiotic policy to reduce antibiotic resistance and decrease use of C.diff promoting antibiotics.
*Implement local chronic pain guidance. Link with patient pathway for chronic pain.
*Review patients prescribed high dose PPIs ensuring where clinically appropriate they are switched from treatment to maintenance doses. -£30,000
*Improved access to end of life drugs. +£5000

Innovation

*Encourage implementation of Vitamin D guidance for the treatment of deficiency / insufficiency whilst ensuring licensed products are used for appropriate length of treatment period -£40,000
*Horizon scanning new drugs and NICE TA/Guidance and identifying associated cost pressures to the CCG.
*Implement agreed inhaler choices for asthma and COPD patients in community and hospital. -£100,000
*Improvement of electronic prescribing systems. CCG to support facilitation and engagement of process to improve reaching 60% target.

Productivity

*Review the use of emollients, laxatives, ISMN and Mezalazine and where appropriate switching to a more cost effective option. -£125,000
*Review use of unicesed specials and switch to a licened or more cost effective alterative -£40,000
*Review the prescribing medicines of limited clinical evidence of effectiveness and switching to an alternative or de prescribing. -£65,000
*Ensuring generic medicines are prescribed where clinically appropriate -£5,000
*Reviewing Drugs which are due to come off patent and ensuring brand to generic switches are made to maximise savings. -£110,000
*Review patients on stoma products and accessories to identify inefficiencies and develop a desired formulary.
*Ensure the appropriate and cost effective use of oral nutritional supplements: Ensure to Aymes.-£43,000
*Implement Guidelines to improve clinically appropriate and cost-effective prescribing of blood glucose strips -£8,500
*Implement preferred choice of Insulin pen needles.-£50,000
*Cost effective mental health prescribing (Quetiapine XL, Gatalin XL, Venlafa -£145,000

Prevention

*Review patients currently diagnosed with hypertension to optimise treatment, Ensure untreated patients are reviewed and prescribed antihypertensives when clinically appropriate.

Programme Area: Prescribing

Risks and mitigating actions:

Risk of patients not having consistency of treatment across providers. Mitigated through input to acute prescribing groups and community provider liaison
Financial risk for CCG with overspend against GP prescribing budget. Budget needs to consider new technologies, and improving prescribing level and patient level (through PPG) engagement plans with QIPP areas
Variation in delivery of QIPP across practices. Mitigated through intelligent practice level data sources.

Workforce implications
No specific implications identified, but QIPP areas will be prioritised as some require significant level of input from the medicines optimisation team. There is also a need for ongoing work with practices both individually and on a locality basis.

Resource implications 2015/16:

In process of being calculated

KPIs (link to national KPIs):

National and locally identified QIPP indicators for medicines optimisation
Nice Clinical guidelines and Technology Appraisals/guidance

South Kent Coast and Thanet CCGs Commissioning Plans

In May 2014 each East Kent CCG Governing Body approved a five year Strategic Plan and two year Operational Plan to improve health outcomes for their respective population. Following a further year of delivery CCGs have been given an opportunity to revisit and refresh year two of their Operational Plans for approval by each Governing Body on 31st March. The attached are Draft Plans on a Page giving a summary of each CCGs plan for 2015 – 2016. Further work is in progress to finalise these prior to Governing Body approval on 31st March 2014 and submission for consideration by NHS England on April 10th.

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NHS South Kent Coast Clinical Commissioning Group
DRAFT Operational Delivery Plan 2015/16

Welcome

This is the second year of our two year Operational Plan. The plan sets out how we will continue to deliver the Clinical Commissioning Group (CCG) 5 year Strategy that was agreed by our Governing Body in March 2014. It explains our plans for developing high quality out of hospital services, as close to a patient's home as possible, whilst ensuring that hospital services offer first class specialist treatment.

We continue to spend time listening to the views of local people and adjust our plans as we need to, reflecting changes in national policy direction and local circumstances.

We remain committed to ensuring good patient experience and improved health outcomes for the people that live in our area.

Dr Darren Cocker
Clinical Chair

Hazel Carpenter
Accountable Officer

Our Vision

Our mission and vision has been developed through wide consultation and engagement with our membership, patients and the public and our partners across South Kent Coast.

Mission

‘To ensure the best health and care for our community

Vision

Hospital Care	Out-of-Hospital Care
• Acute care requiring specialist facilities, whether for physical or mental health needs, will be highly expert to ensure high quality. • Hospitals will act as a hub for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.	• For services to integrate, wrapping around the most vulnerable to enable them to remain in their own home for as long as possible. • Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions.

NHS South Kent Coast CCG Strategy and Plan

Understanding Our Local Health Needs in 2015/16

The CCG has to place the national context against our local health needs when defining our long term ambitions. Joint Strategic Needs Assessments (JSNAs) for the area are available on South Kent Coast CCG website (www.southkentcoastccg.nhs.uk). These assessments are used to inform us and our local authority partners about the potential health needs of the population.

SUMMARY – SKC POPULATION HEALTH CHALLENGES	
Population	• The proportion of SKC population aged 65+ is 21%, this is the highest proportion of over 65+ within Kent and Medway. 3% of the local population are over 85+. • Life expectancy from birth in the SKC area is estimated to be 80.5 years, marginally better than the East Kent average of 80 years. • However, the range between ward with the highest life expectancy – River (86) – and the lowest – Folkestone Harvey Central (73) – is 13 years.
Inequalities	• 53% of people in Dover, and 60% of people in Shepway are in the bottom 2 deprivation quintiles • SKC has statistically significant correlations between life expectancy and deprivation • Folkestone Harvey, Folkestone Harbour and Castle have over 25% unemployment • The biggest issue for the gap in life expectancy is Heart Disease
Causes of Death	• Circulatory Disease is now the main cause of death, followed by Respiratory Disease and Cancer.
Lifestyles	• Smoking rate - Shepway 21.1% Dover 27.4% • Obesity - Shepway 25.9% Dover 26.8% • SKC is high in Chlamydia prevalence and both has increasing teenage conception rates (particularly Shepway)
Long Term Conditions	• SKC: Higher than Kent average for premature deaths (<75) from CHD • Only 7 out of 31 GP practices come within 75% of the expected prevalence for patients registered with CHD • 15 of the 31 GP practices reach over 60% of the expected prevalence of COPD • 8% of GP practices reach 60% of expected prevalence for hypertension, only 1 reaches 70%
Dementia	• Estimates suggest 3250 people in SKC have Dementia. This is set against confirmed diagnosis of 1599. • The numbers of people with Dementia is set to increase by 837 by 2026

NHS Outcomes

We support the delivery of 5 key national priorities for our local population :

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

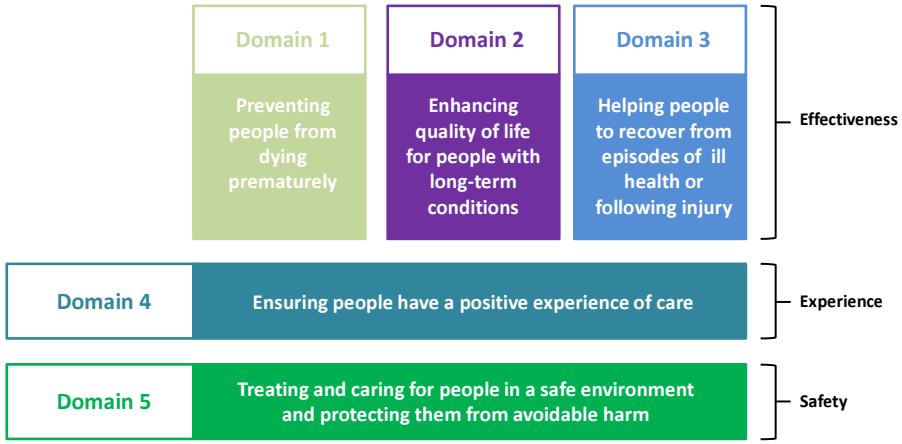


Figure 1

Our Commissioning plans for 2015/16

The predominant commissioning approach in 2015/16 will be to further develop out of hospital care as part of a Multi-specialty Community Provider (MCP) Model (including an application to the *New Models of Care Programme*), underpinned by strong GP clinical leadership and supported by medical specialists. In addition, we will drive schemes which will impact on 'in hospital" pathways in order to meet constitutional targets and improve patient outcomes through seven day working.

Specific areas of focus for the CCG's MCP Model and "in hospital" schemes, reflecting local intelligence, performance and the *NHS Right Care* programme, will be:

Out of Hospital:

- Cardiovascular Disease (including Stroke);
- Respiratory Disease (including Asthma and Chronic Obstructive Airways Disease (COPD)
- Diabetes Care & Treatment improvement;
- Prevention, Self-Care and Self-Management;
- Implementing the 5 point Inequalities Strategy
- End of Life Care;
- All-age Neuro-development (including Attention Deficit and Hyperactivity Disorder (ADHD) and / Autistic Spectrum Disorder (ASD))
- Children with Challenging Behaviour;
- Looked After Children;
- Community Mental Health (including Dementia);
- Better Care Fund Scheme Delivery; (Integrated teams and Re-ablement, Falls Prevention, Enhance Primary Care, Enhance Care Home Support, Enhance Practice Level Teams, Integrated health & Social Housing)
- 111/Out of hours re-procurement
- Frailty Pathway

In Hospital:

- Cancer Diagnosis, Treatment & Recovery;
- Dermatology;
- Orthopaedics;
- Cardiovascular Vascular Disease – acute management of stroke and vascular services review
- Psychiatric Liaison
- A& E
- Diagnostics central point of referral

Delivery of Improved Outcomes

The table below illustrates how our local plans align with the NHS Outcome Framework domains, challenges in 2014/15, and local health needs identified through Commissioning for Value analysis (CFV).

	progress and challenges in 2014/15	plans in 15/16	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	CFV
Programme Area: Out of Hospital								
Better Care Fund Scheme Delivery; (Integrated teams and Reablement, Falls Prevention, Enhance Primary Care, Enhance Care Home Support, Enhance Practice Level Teams, Integrated health & Social Housing)	redesign of the existing community nursing services, alignment of community nursing teams with GP practices, agreement of enhanced roles of community and specialist nurses , Revision of service specification underway to integrate health intermediate care, Kent social services enablement services and mental health home treatment services, Enhanced care home support fully implemented and showing 10% reduction in A&E attendance, piloting increased access to primary care via prime ministers challenge fund, proactive care planning for over 75's in place improvements to electronic record sharing and pathway management initiated , working with social services on implementation of accommodation strategy	High risk patients identified and managed in community pro-actively by the practice level multi-disciplinary team Fully integrated health and social care intermediate care services revise falls pathway in conjunction with public health expansion of record sharing and pathway management		x	x	x		x
Respiratory Disease (including Asthma and Chronic Obstructive Airways Disease (COPD)	Health economy wide COPD pathway agreed and supported with 2 year Commissioning for Quality and Innovation (CQUIN) targets.	pathway to be launched in April	x	x		x		x
Cardio Vascular Disease (including stroke)	work plan in place, Atrial fibrillation medication management agreed in line with national guidance	continue with delivery against work plan	x		x	x		x
Diabetes care and treatment	health economy wide agreement of new diabetes management pathway piloting	pathway implemented		x		x		x

Delivery of Improved Outcomes cont.

	progress and challenges in 2014/15	plans in 15/16	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5		CFV
Prevention, Self-Care and Self-Management	developing plan from "Patients in Control" programme	implement plan			x		x		
End of Life Care	Strategy and work plan in place and updated	work plan implemented			x		x		
community mental health including dementia	psychiatric liaison pilot,	procurement of eating disorders, all age Attention Deficit Hyperactive Disorder and Autistic Spectrum Ccndition	x		x	x	x	x	x
All-age Neuro-development		procurement of all-age Attention Deficit and Hyperactivity Disorder and Autistic Spectrum Disorder service			x		x		
Programme Area : In Hospital									
Dermatology	Increase in referrals to dermatology and Orthopaedics services contributed to pressures in acute services to meet treatment waiting times targets.	develop single point of access service for dermatology					x	x	
Orthopaedics	new single point of access service has been established providing multidisciplinary review of referrals to ensure the patient is seen by the most appropriate service.	NHS elect musculoskeletal pathway redesign				x	x	x	x
Cancer	Improved booking system in place	monitoring at speciality level	x				x	x	x
CVD – acute management of stroke	Pathway developed	Implementation	x		x				x
Psychiatric Liaison	Pilot 24/7 service established across 3 acute sites	Expanded service		x	x				
A&E	"Perfect Week" initiative completed to identify system improvements	continued implementation of action plan	x			x			

Our approach to contracting in 2015/16

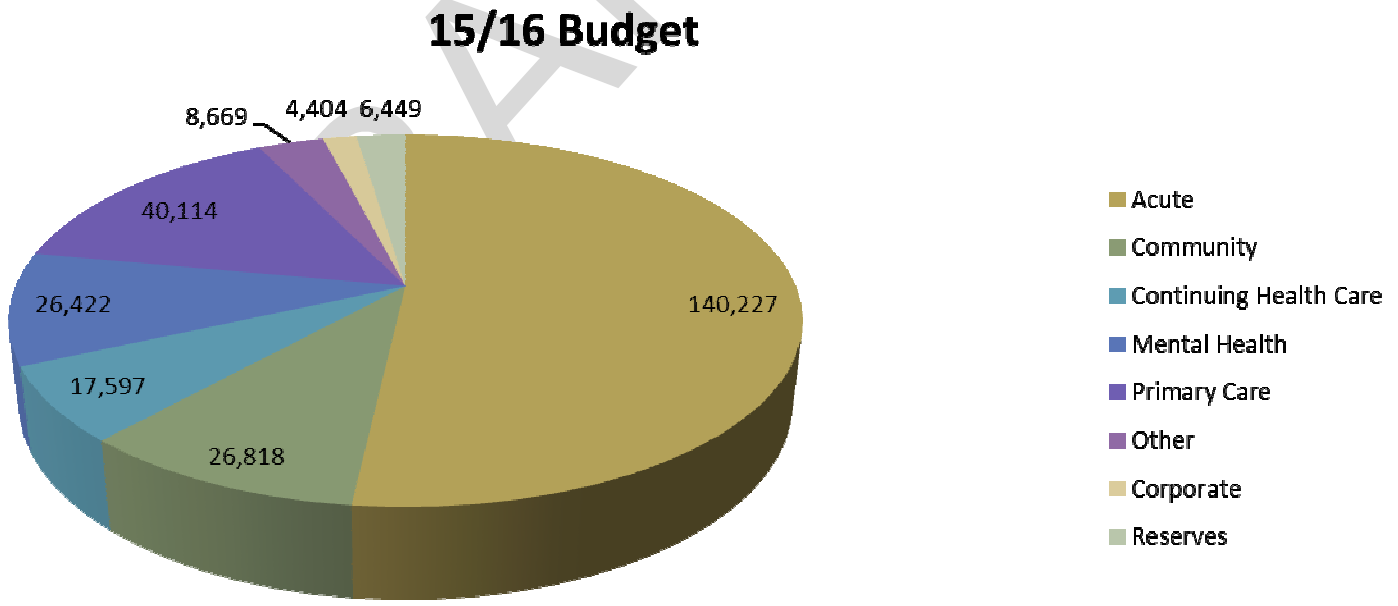
- The CCG will work to further integrate Health and Social Care services through delivery of the Better Care Fund (BCF). This programme will be the vehicle by which the local system, through early identification of deterioration, will achieve reductions in A&E attendance and subsequent admission and premature admissions to long term care.
- The CCG will negotiate a 2015/16 contract with East Kent Hospitals University Foundation Trust (EKHUFT) that provides financial security to both the Trust and the CCG, by limiting the reliance upon activity counting and unit prices. This will reduce bureaucracy and allow focus on improving patient services and delivering value for money.
- The CCG will ensure that parity of esteem for mental health patients is captured within all contracts for 2015/16.
- The CCG will continue to develop the Local Health Economy (LHE) Workforce, including a Health and Social Care Apprenticeship Programme, to ensure 'right care' by the 'right person' at the 'right time', to provide clinical leadership and support recruitment and retention. All with the intention of supporting delivery of our transformative plans for new models of care.
- The CCG will develop system integration via the Medical Interoperability Gateway (M.I.G) where access to the patient GP record (with patient consent) will be visible across multiple providers to avoid duplication and improving care for patients by enabling them to tell 'us once'.
- Commissioning for Quality and Innovation (CQUIN) measures will be targeted towards incentivising a continued focus on patients aged over 75, to compliment the named GP policy incentivised as part of change to GP contracts from April 2015. CQUINs of all major providers will be tailored towards adding capacity and capability to South Kent Coast's already successful neighbourhood teams, which currently bring together GPs, Social Services and Community Services to deliver improved outcomes for all residents.

Our financial approach in 2015/16

South Kent Coast CCG has a baseline budget of £270.7m for 2015/16; this delivers a 1% surplus of £2.7m.

The budget for 2015/16 is based on the outturn of 2014/15. The budget was adjusted for non-recurrent spend, growth, full year effects of QIPP schemes not delivered in 2014/15, cost pressures and required savings.

Demographic change based on the forecast population increase has been calculated at 0.9%, based on Office of National Statistics figures combined with the shifting age profile of the population. In addition to this, ambulance and prescribing have a demand uplift of 5%, following historic trends and NICE guidance. Placements growth is estimated at 8% as per current trends.

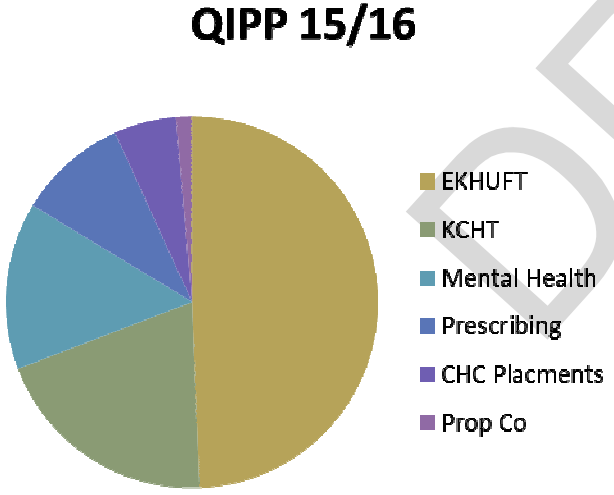


Our financial approach in 2015/16

The CCG is aiming to deliver £6.3m of net QIPP savings in 2015/16. £3.1m of this is attributable to the contract with EKHUFT. This will include targeted reductions in outpatients, anticipating a fall in referrals and reduction in low value follow-ups. There is also anticipated a reduction in activity relating to new pathways developed in COPD, Heart Failure and improved over 75s management. This figure also includes 1% reduction in non-elective activity due to the improvement of integrated health and social care services through the better care fund. There will be cap and collar arrangements in the contract with EKHUFT as in 14/15. To help support EKHUFT to make the changes needed to their services to release long term savings the CCG has allocated its top slice of £2.6m non-recurrently to this contract.

The CCG is planning £1.2m of savings to be delivered from the KCHT contract. This will be delivered through service redesign, beginning with community nursing.

During 13/14 and 14/15 the CCG invested in local mental health services to reduce expensive out of area placements. The impact has been delayed, leading to a large overspend on mental health services. For 2015/16 further investment is pledged locally, and contracting arrangements changed to incentivise local treatment. As a result the CCG is planning a decrease in out of area costs, with a higher quality and more efficient service from local mental health providers.



Other QIPP areas:

Placements - improved management of existing placements and placing of new individuals is expected to lead to a saving on placements. There should be also be savings made from the improvement in community beds usage, leading to a reduction in placement referrals.

Prescribing - savings are anticipated from focussing on value for money prescribing, reducing variation in practice in primary care including a continued focus on antibiotic prescribing.

Prop Co - savings are planned from better use of NHS property in the CCG and reduction in void spaces.

Our approach to improving quality in 2015/16

Patients and the quality of the care they receive is the focus of everything we do. Our job is to commission clinical services for the local population which must provide good experience, be of high quality and have the best possible outcomes for patients. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.

As well as promoting on-going quality improvement, commissioners need to assure themselves that existing services meet acceptable standards. Whilst regulators play a key role in this arena, commissioners must still actively monitor the quality of services delivered by our providers.

Our approach to quality has been informed by 3 key national quality reports following incidents at Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital;

Francis Report

- Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013
- The report considers and makes recommendations on a range of issues;

1. How to embed the patient voice throughout the system
2. How to engage health care staff generally in the leadership of their organisations
3. The standards set for safety and quality of care
4. The collection, use and sharing of information and data

Berwick Report

- Following the Francis Report, Don Berwick led a national advisory group around Patient Safety. The report details the specific changes required in the NHS as a result of the Francis and Keogh inquiries;
- Four guiding principles fall out of this report;

1. Place the quality and safety of patient care above all other aims for the NHS
2. Engage, empower, and hear patients and carers throughout the entire system, and at all time
3. Foster wholeheartedly the growth and development of all staff
4. Insist upon, and model in your own work, thorough transparency

Winterbourne Report

- Report following the uncovering of years of physical and psychological abuse of patients with learning disabilities (LD) and challenging behaviour, at Winterbourne View Hospital
- Highlighted the need to stop hospitals becoming homes for LD patients
- CCG responsible for jointly reviewing with local authority partners all patients in NHS funded in-patient LD facilities
- CCG responsible for finding supported community placements with appropriate personal care planning in place for these patients

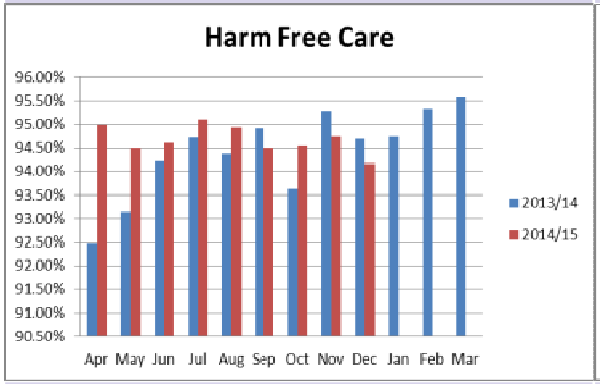
Our approach to improving quality in 2015/16

How the CCG Measure Quality

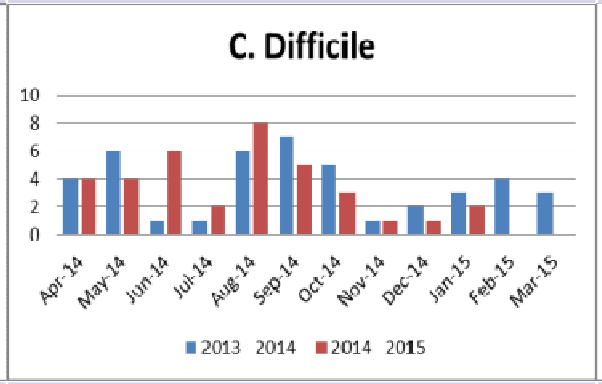
The CCG work to ensure that all commissioned services meet the CQC fundamental standards of quality and safety. The NHS Outcomes, CCG Quality Metrics and CQC Domains are all aligned as described below.

QUALITY METRICS

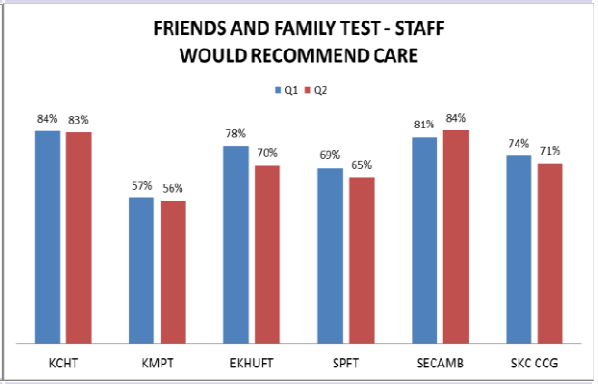
Harm Free Care



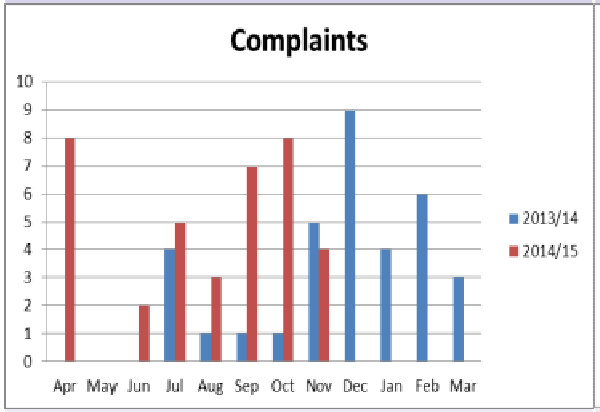
Health Care Associated Infections



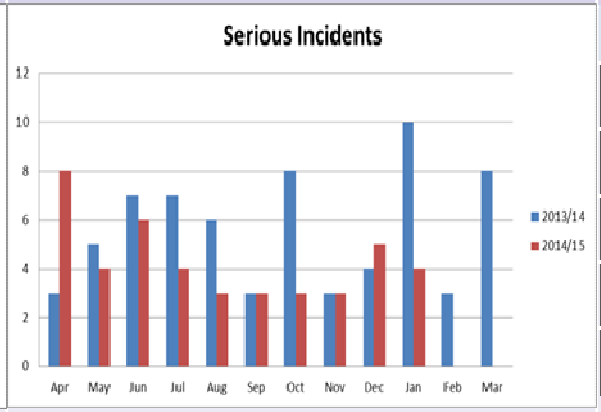
Friends & Family Test



Complaints



Serious Incidents



Care Quality Commission

CQC Domains	EKHUFT	KCHT	KMPT	SECAMB	NSL	Independent sector
Safe	Inadequate	Good	Met Standard	Met Standard	Met Standard	Met Standard
Effective	Requires Improvement	Requires Improvement	Met Standard	Met Standard	Not Met Standard	Met Standard
Caring	Good	Good	Met Standard	Met Standard	Not Met Standard	Met Standard
Responsive	Requires Improvement	Good	Met Standard	Met Standard	Met Standard	Met Standard
Well-Led	Inadequate	Good	Met Standard	Met Standard	Met Standard	Met Standard

Our approach to improving quality (CQUINs) in 2015/16

Central to our strategic approach is our ambition to deliver quality related improvement whilst reducing spend. There is commitment across the local health and social care system to develop and deliver integrated care via a new model of care that ensures alignment of commissioner and provider plans. The areas of attention will be:

•Focus on specific health needs and areas of pressure identified in our strategy
•Support the level of integration we expect between our hospital and out of hospital service providers
•Support the system change we require to make the local health system fit for the future

Respiratory	Over 75 years with LTC	Diabetes	CVD
2015/16	2015/16	2015/16	2015/16
Work collaboratively to embed and measure performance of new integrated care pathway for COPD patients, with ultimate aims being to; •Reduce non-elective admission / re-admission By; •Delivering care close to home •Improving transfer of care •Improving self-management	Embed and measure performance, with ultimate aims being to; •Develop a collaborative shared care plan approach •Improve transfer of care between providers •Improve the safety and quality of patient care	Embed and measure performance, with ultimate aims being to; •Reduce non-elective admission / re-admission By; •Delivering care close to home •Improving transfer of care •Improving self-management	Work collaboratively to embed and measure performance of new integrated care pathway for Heart Failure patients, with ultimate aims being to; •Reduce non-elective admission / re-admission By; •Delivering care close to home •Improving transfer of care •Improving self-management

Our approach to improving quality (CQUINs) in 2015-16

To further support our strategic ambition to close the gap between mental and physical health, we have devised 3 local quality incentives with our main mental health service provider – Kent and Medway Partnership Trust (KMPT). The quality incentives will;

- Focus on specific health needs and areas of pressure identified in our strategy
- Support the level of integration we expect between our hospital and out of hospital service providers
- Support the system change we require to make the local health system fit for the future

Transition from adolescent to Adult Mental Health care	Dementia	Crisis Plans
2015/16	2015/16	2015/16
Full implementation of safe effective transition pathway for adolescence from CAMHS to adult mental health services	Full implementation of ratified multi-agency integrated pathway for patients with Dementia	Full implementation of agreed % crisis plans across key acute cluster pathways. Reduced crisis episodes and unplanned admissions

Out of Hospital Programme

From:	By doing what:	To:

'The professionals involved in my care do not appear to communicate with one another. I have to repeat my story every time.'
 	
'I do not know who the main person in charge of my care is.'
 	
'When I was discharged from hospital to my home, I was not clear on what would happen next.'
 	
'I panic when my condition deteriorates. I do not know who to contact.'
 	
'The care and support I receive has made me dependent on others. I feel no longer able to live my life independently.'
	SYSTEM CHANGES
	
	• The development of four Multi-specialty Community Provider 'hubs' (underpinned by an application to the *New Models of Care Programme*) offering specialist advice and support, including urgent and planned care responses, in:
	  • Deal
	  • Dover
	  • Folkestone
	  • Romney Marsh (including Hythe) (see model page 18)
	
	• The development of multi-disciplinary integrated working at General Practice level - including social care and mental health - to improve management of patients longer terms needs in a proactive way. This will include promoting prevention, self-care and self-management and extend to enhanced support for patients in care homes;
	
	• Further mobilisation of the Medical Interoperability Gateway (M.I.G) to ensure access to patients' GP records across multiple providers (with patient consent) to avoid duplication and improving care for patients by enabling them to tell providers 'once';
	
	• Mobilisation of community assets to ensure reaching as much of the population possible via District councils, domiciliary care agencies and voluntary organisations;
		'The professionals involved with me talked to each other. I could see that they worked as a team'
		
		'I had one first point of contact. They understood both me and my condition(s). I could go to them with questions at any time.'
		
		'When I moved between services or settings, there was a plan in place for what happened next.'
		
		'I had systems in place so that I could get help at an early stage to avoid a crisis'
		
		Taken together, my care and support helped me live the life I want to the best of my ability'

Out of Hospital Programme

From:	By doing what:	To:
'I do not know what to do and where to go in an emergency.'	**PATHWAY SPECIFIC CHANGE** •**Cardiovascular disease*** **-** focussing on improved prevention and management of stroke, anti-coagulation and community DVT services; •**Children with Challenging Behaviour -** development of a new multi-agency intensive support team model; •**Community Nursing -** implementation of a practice level model to ensure that care is coordinated for vulnerable patients groups together with GPs Specialist Nursing – broaden the skills of specialist nurses to be able to manage a greater elements of the pathways for patients with long term conditions; •**Diabetes*** **-** implementation of a Type 2 Diabetes primary care training programme and an Integrated Diabetes Care Pathway; •**End of Life -** improved co-ordination and timeliness of care via a palliative care education programme, increased specialist bereavement counselling and procurement of system wide electronic palliative care system; •**Falls*** - improved prevention via a refreshed falls pathway between health, social care and public health; •**Intermediate Care -** to integrate health and social care elements of intermediate care services to reduce duplication and increase the skill of those delivering intermediate care to build capacity and resilience; •**Looked After Children -** re-procurement of LAC service; •**Respiratory Disease* (including Asthma and (COPD) -** implementing integrated pathways / services. ***NHS Right Care: Commissioning for Value Schemes**	'I could plan ahead and stay in control in emergencies'
'I was not provided with good information about my condition following diagnosis. I no longer feel able to manage without support.'		'I had the information and support I needed in order to remain as independent as possible'
'I was not given the opportunity to input into future care arrangements should my condition worsen.'		'Information about me, including my views and preferences and any agree care plan, was passed on in advance'
'I only have a quick review of my care and treatment once a year. '		'I has regular reviews of my care and treatment, and of my care plan'
'I struggled to keep on top of my medicines regime. Are they all still working?'		'I had regular, comprehensive reviews of my medicines'

Multi-speciality Community Provider (MCP) Model
(Community Hubs / Primary Care)

NHS South Kent Coast Clinical Commissioning Group

NHS 111 / Care Navigation / Out of Hours Medical Services / KCC Out of Hours

Central Hub

(8am-8pm -> Paramedics 8pm–8am / 365 days)

URGENT RESPONSE SUPPORT

(KCC SHORT TERM PATHWAY)

- GP Service with Physician Associates (branch to local surgeries) - Urgent Appointments
- Minor Injuries with
  - Nurse Practitioners (Minor illness overflow from GP service)
  - Paramedic Practitioners (GP home visits, rapid response, cover in MIU)
  - Rapid Response Nursing (Support to PPs, cover in MIU)
- Integrated Intermediate Care (includes KEAH) (Social care/KEAH Supervisors, Therapeutics, other HCPs, MDT support to ICT beds)
- Ambulatory Care (initial Treatment)

- Voluntary Organisations
- Housing/Benefits Advice
- KCC Assessments Clinics

MEDICAL SPECIALISTS (as part of MCP)

Mental Health Services (Urgent & Planned)

DIAGNOSTICS 8am-8pm 7/7

PLANNED CARE

- Out patients – One stop "initial consultations, follow-up face-to-face or virtual via telemedicine/telephone with consultants,
- Ambulatory Care (follow up)
- MSK Physiotherapy
- Occupational Therapy
- Special & Language Therapy
- Clinical Nutrition & Dietetic Service
- Sexual health services
- Community Orthopaedic Services
- Chronic Pain Services
- Podiatry Services
- Diabetes, Lymphodema , Cardiac, Epilepsy, Respiratory, Nurse Led Clinics

- Linked IT / Shared Records / Care Plans - **'Tell us once'**

- Community Support via ie: Voluntary Orgs, Community Wardens
- Domiciliary Care Services – Early Identification of deterioration
- Access to Step-up / Step-down Beds
- Children's Centres

General Practice

(6.30pm – 8.00pm Mon-Fri/Sat,Sun & BH's 8am-8pm covered via the 'Hub')

LONGER TERM MANAGEMENT

(KCC Adult Community Teams)

- GP's
- Nursing team (Practice nurse, Nurse Practitioner, Community Nurses, Specialist Nurse, Hospice CNS)
- Mental Health Workers / Mental Health Specialists
- Medicines Management Support / Pharmacy
- Health Trainers (Health Checks/Prevention/Self Care/Empowerment/Carers Health)
- Case Managers (Adult Social Care)
- Health Visitors
- Midwifes
- Children's Community Nursing
- Care Navigators (General & Mental Health)
- Cardio / Pulmonary Rehabilitation
- Continence Services

East Kent Wide Community Services

Acute Services (General & Mental Health) Integrated Discharge Team

SEC/Amb 99

Equipment Services / KCC Fast Track Equipment Provision

Patient Transport

Minor Surgery / Community

Dental Services

Accessible Care / Co-ordinated Care / Proactive Care/Personalisation
' No wrong door ' 'Every contact counts'

Clinical Leadership / Workforce Development

Mobilise Community Assets to Build Resilience

Out of hospital performance targets

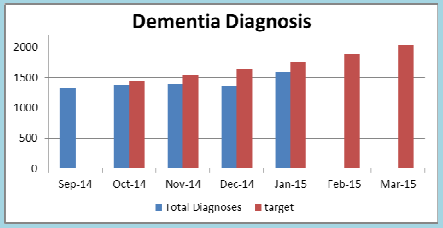
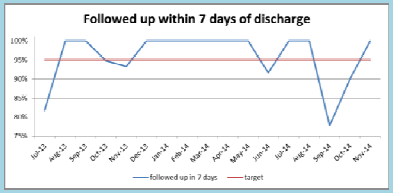
Out of hospital key performance metrics	Planned 15/16
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	104.71 (Reduction of 1%)
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	300 (Reduction of 3.2%)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	88.5% (Increase of 2.8%)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	943 at Q4 (Reduction of 3.5%)
Patient user survey: percentage of people feeling supported to manage long term condition	70% (Increase of 4%)
Admissions due to falls in people aged 65 and over	1035 (Reduction of 5%, 284 people per 100,000)
KCHT admission avoidance long term conditions and intermediate care team	5% increase
use of community hospital beds step up	Target 60%
use of community hospital beds step down	Target 40%
Reduced length of stay (non elective episodes of care for chronic long term conditions and dementia)	Reduction of 5%
Reducing hospital admissions for patients with chronic long term conditions and dementia	Reduction of 7%
30 day readmission rates	reduction of 5%

- Mental Health Programme

From:	By doing what:	To:
'I had to wait too long for an assessment '.	**SYSTEM CHANGES** •**Community Mental health Team Redesign –** Alignment with older people mental health and crisis team to reduce silo working, improve transfer of care between mental health services to improve patient outcomes and experience whilst increased efficiency and extended hours •**Mental health Personal Health Budgets** – Providing flexibility to meet gaps in services to meet peoples needs to promote choice in provision in mental health services •**IAPT Re-procurement** *– to improve access for hard to reach groups, to be closer aligned to both primary care and acute services for a more integrated mental health service **PATHWAY SPECIFIC CHANGES** •**Community Mental Health and Wellbeing (including dementia)* -** integration of a series of community-based providers to provide a consistent model of community early mental health intervention, increasing diagnosis, support and preventing the need for secondary care. •**All-age Neuro-development Pathway (including ADHD and ASC)** - procurement of an integrated community specialist service for adults and children; •**All-age Eating Disorder Pathway –** procurement of an integrated community eating disorder service •**Acute Liaison Psychiatry** * - Embed a more sustainable service to reduce 136 sections and ensure improved patient experience and outcomes in an acute hospital setting. •**Personality Disorder** – improve the current provision in Folkestone for the benefit of more patients with a personality disorder	**'I was seen quickly by the psychiatrist and given a clear treatment plan'**
'All of my health needs have never been considered in one place'		**My mental health team understood my physical health problems and helped me get the support I needed'**
'I went to A&E and had to wait hours for psychiatric help'		**'My condition was stabilised and I was discharged back home and visited by a CPN on the same day.'**
'I was placed in a bed miles away from my home and family.'		**'I was admitted to a bed in the nearest mental health unit'**
'I was not told about the side effects of my medication. I became unwell again and went back to A&E.'		**'My care plan gave me good information about my medication and how to manage the possible side effects'**

*Achieving Better Access to Mental health Services 2020/Commissioning for Value

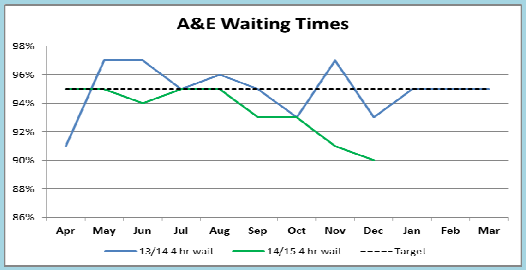
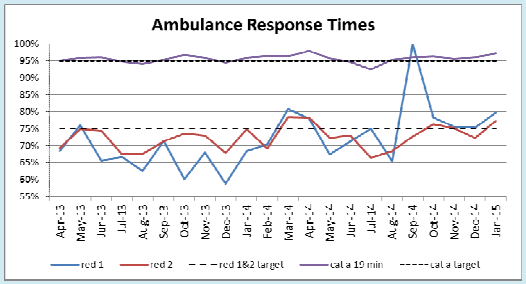
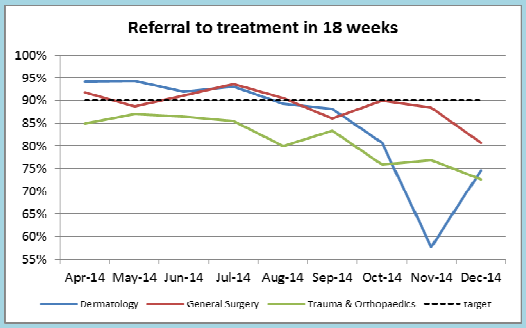
Mental Health Performance

	Target	Performance in 2014/15	Challenges and Improvement Plan
Mental Health			
Dementia			
% diagnosis rate	66.7%		The CCG aims to improve the identification and care for patients with Dementia. Throughout 2014/15 actions have been taken to increase the number of patients identified as having dementia in all GP practices, including data cleansing and programmes of training and support for practices to sign post and support patients following diagnosis. Practices in SKC have made significant improvement in their rate of diagnosis, with further work planned for 2015/16.
In-patient follow-up			
Follow-up within 7 days after discharge from in-patient care	95%		Exception reports for non-compliance are reviewed through contract meetings.
Improved Access to Psychological Therapy (IAPT)			
IAPT access proportion	15%	<table><tr><th></th><th>Target</th><th>Q1</th><th>Q2</th><th>Q3</th></tr><tr><td>% recovery rate</td><td>50%</td><td>54%</td><td>49%</td><td>52%</td></tr><tr><td>% of need entered treatment</td><td>15%</td><td>22%</td><td>23%</td><td>20%</td></tr></table>	South Kent Coast CCG continues to exceed the target rate for access to psychological therapies. Targets for recovery rates are met for 2014/15. The CCG continues to monitor access and outcomes for psychological therapy on a monthly basis.
IAPT recovery rate	50%		
Treated within 6 weeks of referral	75%	As of January 2015 – average 93% compliance	To be monitored monthly as a new national target in 2015/16
Treated within 18 weeks of referral	95%	As of January 2015 – average 100% compliance	To be monitored monthly as a new national target in 2015/16
Early Intervention in Psychosis			
Treated within 2 weeks of referral	50%	By April 2016	To be monitored monthly as a new national target in 2015/16

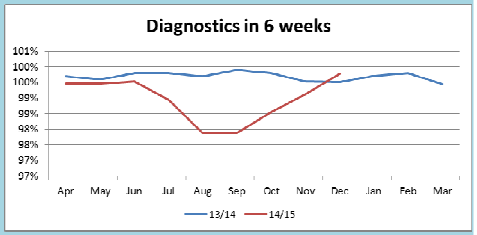
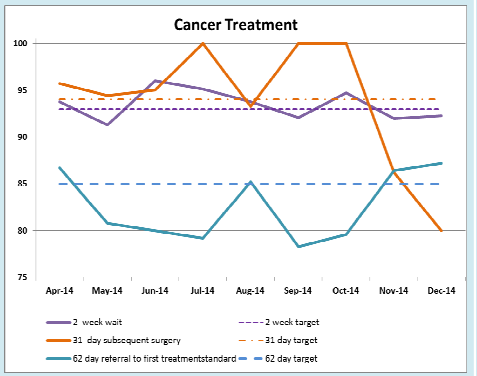
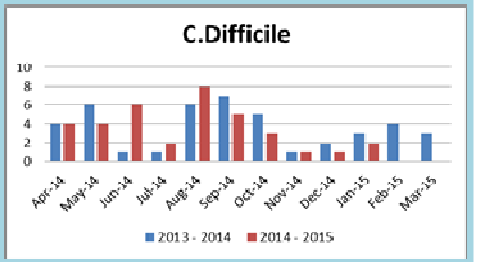
Hospital Programme

From:	By doing what:	To:
'I had to make 3 or 4 trips to hospital to receive consultations and tests before I was diagnosed.' **'I was admitted to hospital over night when my condition worsened. I had to wait longer than expected for my discharge arrangements to be made.** **'I was not asked my view on my treatment post-discharge. I was placed in a bed miles away from my home and family.'** **'I was not told about the side effects of my medication. I became unwell again and went back to A&E.'**	**SYSTEM CHANGES** • **Accident & Emergency 4 Hour Access Target-** Have in place clear parameters for success and performance monitoring. Testing full 7 Day working across the whole system. Developing an 'Early Warning System' to ensure patients are discharged or transferred between providers in a safe and effective way. Ensuring effective and appropriate escalation processes are embedded across the health and social care economy. Being clear about the messages we share with the Public regarding alternate pathways for accessing healthcare admission avoidance schemes as relevant. Learning from the two 'Perfect Week' programmes • **EKHUFT Outpatient Strategy** - the CCG will continue to engage with the Trust as it progresses towards consolidation of its outpatient services on six sites, in particular ensuring equitable access to outpatient services for Deal and Shepway patients; • **Outpatient Follow-Ups** - the CCG will work with EKHUFT and other secondary care providers on new models to follow-up patients secondary care, such as open access / patient initiated and telephone follow-ups. **PATHWAY SPECIFIC CHANGES** • **Cancer*** - focussing on improved diagnosis, sustained Cancer Waiting Times (CWTs) compliance, treatment and recovery / survivorship; • **Cardiovascular disease*** - focussing on improved acute management of stroke; • **Dermatology** - full pathway review to develop an integrated pathway that supports appropriate patients in the community rather than default referral to EKHUFT and impact upon their RTT compliance; • **Orthopaedics*** - continuation of the Collaborative Orthopaedic Referral Point (CORP) Pilot, including review, to continue to ensure inappropriate orthopaedic referrals do not default to EKHUFT and impact upon their RTT compliance. ***NHS Right Care: Commissioning for Value Schemes**	**'There were no big gaps between seeing the doctor, going for a test, getting the results and a treatment plan.'** **'My condition was stabilised and I was discharged back home and visited by my community nurse on the same day.'** **'I was involved in the discussions and decisions about my out of hospital care and treatment before I was discharged.'** **'On discharge I was given information about any medicines I was taking with me – their purpose, how to take them, potential side effects.'**

In Hospital Performance

	Target	Performance in 2014/15	Challenges and Improvement Plan
NHS constitution standards			
A&E waits			
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%		Nationally reported increases is A&E activity in 2014/15 have resulted in increased demand on acute services. Multi-agency work has been underway to identify key challenges. An action plan has been developed to address system wide and operational improvements. These plans are monitored weekly against achievement of the agreed target recovery trajectory.
Cat A Ambulance calls			
Category A calls resulting in an emergency response arriving within 8 minutes – Red 1	75%		Achievement of the national targets for ambulance response times has been variable throughout the year. Recruitment of additional paramedics has been initiated in 2014/15, with plan s in 2015/16 to train additional paramedic practitioners. Development of an improved integrated local first responders team is planned for 2015/16.
Category A calls resulting in an emergency response arriving within 8 minutes – Red 2	75%		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%		
Referral To Treatment waiting times for non-urgent consultant-led treatment			
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%		EKHUFT has failed to achieve the national referral to treatment standard this year. This is due to a growth in referrals into the hospital, particular those relating to Trauma and Orthopaedics. A recovery plan was put in place which included a commitment to clear the backlog. This led to a further reduction in performance as 18+ week waiters were moved to treatment. The recovery plan was initially expected to ensure compliance by April 2015, but difficulties in reducing the backlog mean that compliance is now unlikely until Q2 2015/16. A single point of access for orthopaedic referrals has been introduced in 2015, showing a significant reduction in referrals from SKC.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%		

In Hospital Performance cont.

	Target	Performance in 2014/15	Challenges and Improvement Plan
Diagnostic test waiting times			
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%		Staffing challenges in acute services resulted in a dip in performance in 2014/15. Action plans to resolve the issues were completed to plan, and performance has since shown a consistent improvement.
Cancer waits			
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer or patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%		Achievement of cancer targets has been variable throughout 2014/15, with the majority of challenges arising in 2 week waits for first appointment, and 31 day wait for subsequent surgery. The overall target of 62 days from referral to first treatment was challenging throughout the year, but has shown improvement and recovered performance to standard. EKHUFT has made significant improvements to booking procedure allowing the service. Monitoring of the targets at specialty level will continue in 2015/16.
Maximum one month (31-day) wait from diagnosis to first definitive or subsequent treatment	96%-all 94/98% - subsequent		
Maximum two-month (62-day) wait from urgent GP or NHS screening referral to first definitive treatment for cancer	85% - GP, 90% - screening		
Infection			
Number of C. difficile infections	<=39		The CCG Participates in the Kent & Medway HCAI Improvement Group. The group has established a Task & Finish Group to review and agree outcomes from post-72 hour CDI cases which may result in lapses of care having occurred. Significant lapses may incur financial sanctions at the end of the year if specific criteria are met. A Green Card scheme has been implemented in East Kent to raise awareness of the risk of recurring infection with C. difficile in previously positive patients. The scheme focuses on awareness of both patients and GPs. The medicines management team works to ensure antimicrobial prescribing is in line with local formulary avoiding high risk antibiotics.

Our approach to improving Health Inequalities in 2015/16

South Kent Coast Health Inequalities Improvement Approach

Health Inequalities Strategy

- **Improving Equity in Access and Treatment:** through delivery of services in a proportionate way that permits outcomes to be the same, regardless of gender, ethnicity, age, vulnerability and deprivation, and using equity audits to inform commissioning.
- **Doing the Job Properly:** ensuring that all member practices, and each organisation with which the CCG works in partnership, understand where their own responsibility lies in contributing to the reduction in health inequalities, and are held to account for delivering it
- **Being Leaders:** recognising and using the influence of the CCG and its member practices to influence and shape policies and practices that have an impact on health and wellbeing, and to be advocates for our patients
- **Making Every Contact Count:** ensuring that services are welcoming and sufficiently flexible in their working practices to respond to the needs of patients with complex needs, and enabling patients to act on the information they are given to improve their own health and wellbeing
- **Going the Extra Mile:** supporting practices and services to work harder and go further for their own most deprived and vulnerable patients and in their care provision for other groups with complex needs including offenders, troubled families, looked after children and adults, and children with learning disabilities

Health Inequalities Work Plan

- Commission at least two Equity Audits each year covering the whole pathway of care on areas that contribute most to premature mortality in the CCG area. The results will be used to inform commissioning and provide the basis of a Health Inequalities position statement to be published in its annual report.
- We will ensure high quality and equitable pathways for Cardiovascular disease with appropriate public health alignment and input.
- We will commission a tailored package of support for most 'vulnerable' practices including a Proactive Vascular Check project that is piloted in the practices with the highest levels of health of inequalities
- We will ensure clinicians lead the focus on health inequalities amongst their member practices by visiting their peers in order to discuss and listen to their experiences of providing equitable services, and to learn from the successes and difficulties they encounter, and to try and influence behavioural change.
- Protected Learning Time and Membership Council sessions will include training on health inequalities; covering evidence about inequity, what works, and practical steps moving forwards.

Our approach to Governance and Assurance in 2015/16

•The Governing Body Assurance Framework identifies the CCG's key strategic risks. These include delivery of our strategic objectives, statutory targets and statutory obligations. The Governing Body reviews the Assurance Framework regularly to ensure that the risks are being managed and effectively mitigated.

•All of the GP practices in SKC are members of the CCG. They meet throughout the year, four times informally and twice formally and in public. The GP practices have been engaged in developing the CCG Plan. The Governing Body regularly reviews the delivery of the CCG Plan, hearing from the Lay Member about public and patient engagement, considers the performance of its key providers, and reviews the financial position of the CCG. The Clinical Cabinet provides clinical leadership for the delivery of the CCG Plan and strategic clinical oversight.

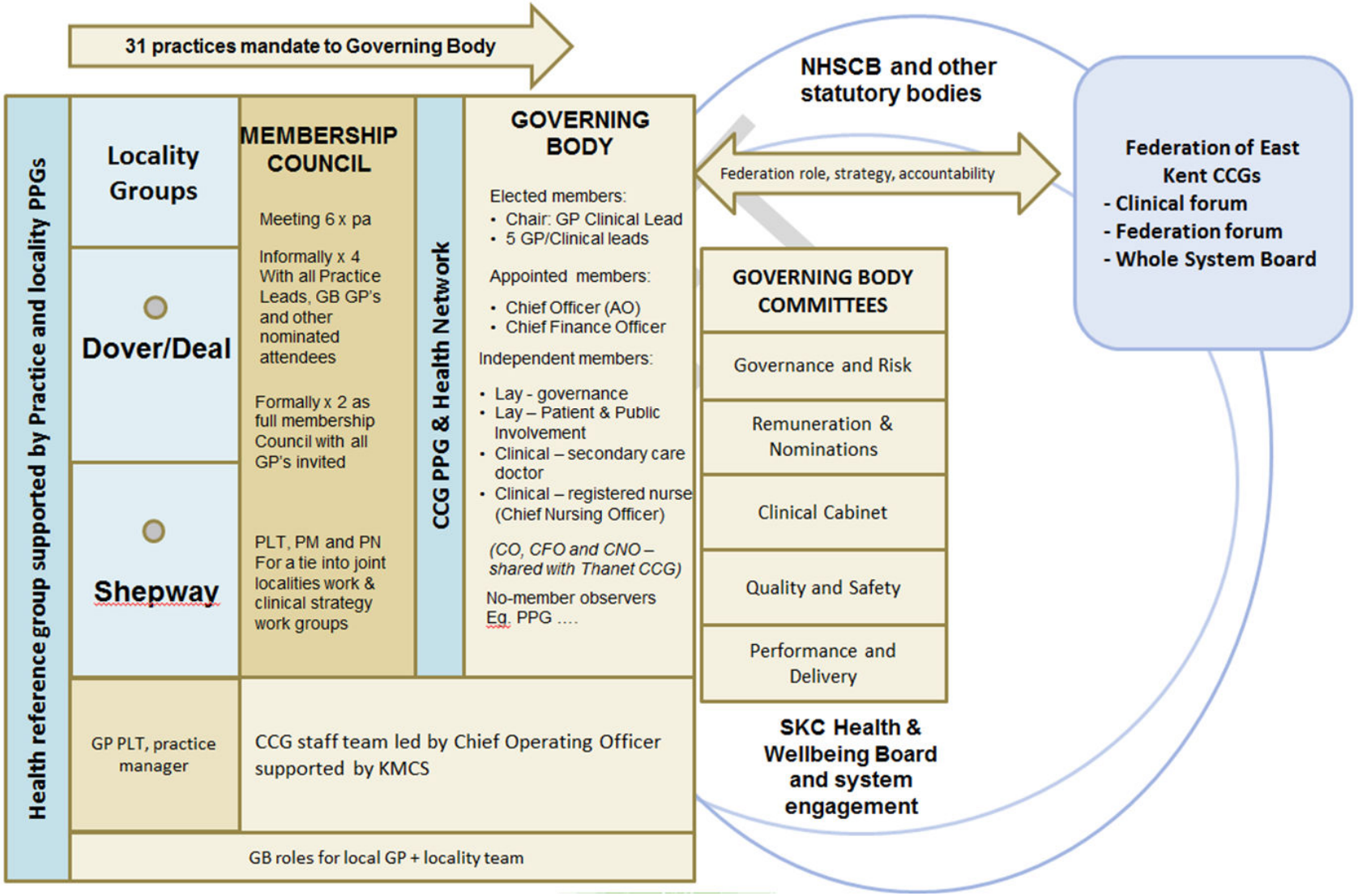
•Monitoring the performance of the providers is a key responsibility of the Governing Body. A detailed review of quality and performance takes place at the Quality and Performance Committee, which focuses on reviewing the delivery of quality and constitutional targets, including A&E attendance, cancer targets, referral to treatment times and dementia. It identifies issues for escalation to the contract performance meetings and monitors local recovery plans to address these risks. Performance is also monitored weekly by the Executive team which informs the accountability discussions with providers at the contract delivery meetings.

•The Governance and Risk Committee has responsibility for audit and for providing assurance to the Governing Body that the systems and processes which the CCG has in place are working well. The Governance and Risk Committee undertakes "deep dives" into issues of clinical and corporate significance e.g. prescribing. They also review the adequacy of the assurance arrangements which the CCG has in place.

•The CCG cannot deliver its ambitions on its own. We work in partnership, particularly with Dover and Shepway District Councils and all members of our local and county Health and Wellbeing Boards.

Our governance structure that will assure delivery is illustrated below.

SKC Governance Structure



Better Care Fund Plan 2015/16

Vision

The South Kent Coast vision for integrated health and social care, via a Multi-specialty Community Provider (MCP), is for patients to always be at the centre of their care and support, receiving coordinated services that are easy to access 24/7, without organisational barriers, of high quality and which maximise their ability to live independently and safely in their community and in their own homes wherever possible.

We will ensure service users and their carers can navigate the services they need and that their health and well-being needs are always met by the right service in the right location.

We will achieve this by building the MCP model within four localities across South Kent Coast Clinical Commissioning Group, with each comprising of a hub of community and primary care services, undertaking an integrated health and social care approach.

Our plans will be underpinned by a number of Better Care Fund schemes aimed at services working together to provide better support for people with long term conditions, older people and people with disabilities to maintain independence and access earlier treatment in the community, to prevent them needing emergency care in hospital or care homes. Alongside this there will be schemes to support education and empower people to make decisions about their own health and well-being. We will deliver this by:

- Building on and enhancing some of the local projects already implemented or planned and;
- Introducing other schemes to ensure faster evolution of what we are already setting out to achieve.

Changes to service configuration

As set out in the CCGs five year strategy, the overall vision to ensure the best health and care for our community will result in changes to current service configuration. Achieving the CCGs vision will require building sufficient capacity in the community, including the workforce, whilst reducing capacity in acute hospitals in order to deliver the following:

- Out of hospital services to be integrated and wrapped around the most vulnerable to enable them to remain in their own home for as long as possible. Patients will be supported by a package of care focussed on their personal health and wellbeing ambitions;
- Acute hospital services will be specialist facilities whether for physical or mental health needs and will be highly expert to ensure high quality. Hospitals will act as hubs for clinicians to work out from and utilise their skills as part of broader teams as close to the patient as possible.

Patient and service user outcomes

By working in new and innovative ways we aim to achieve the following:
- Focus on prevention and targeted interventions to support peoples overall health and well-being;
- Ensure services respond rapidly and more effectively to patient's needs, especially at times of crisis;
- Support carers and empower individuals to do more for themselves;
- Improve the overall patient experience of the delivery of care.

Aims and objectives of an integrated system

With a high elderly population in South Kent Coast and increasing numbers of people who have one or more long-term condition, we aim to focus the Better Care Fund on prevention, reducing the demand and making the most efficient and effective use of health and social care resources.

Our plans for the Better Care Fund support the delivery of the CCGs five year strategy which has a strong focus on the management of long term conditions and the subsequent impact long term conditions has on the local health systems.

Given the extent of integration set out in our plans, there are considerable changes to the current ways of working and the existing workforce across multiple organisations. This will require us to undertake work to re-shape the supply of the market to enable delivery of our plans over time; this may take the form of an Integrated Care Organisation.

South Kent Coast CCG has developed an Integrated Commissioning Strategy in partnership with the local authority and both Dover and Shepway District Councils. This Strategy identified four shared aims which are working together toward:

- To improve the health and wellbeing of people in Dover and Shepway living with long term conditions, enabling as many people as possible to manage their own condition better;
- People with disabilities and older people will be supported to actively participate in the lives of their local communities, enabled by environments that are inclusive, accessible and safe for all;
- To support families and carers in their caring roles and enable them to actively contribute to their local communities and;
- To ensure that the best possible care is provided at the end of people's lives.

Measuring improved outcomes

By delivering the above aims to will achieve the following outcomes. These measures are monitored using an integrated performance dashboard for the Better Care Fund and monitored monthly through steering groups and the Quality and Performance Committee.

Reduced hospital admissions;	Reduction in duplication;	Carers will have access to good quality information and advice;	Improved end of life care for people with dementia and long term conditions.
Reduced length of stay in hospital;	People will have access to local quality housing that meets their needs;	Carers will be supported to access services to support them in that role;	Ensure services respond rapidly and more effectively;
Timely access to local health and social care services;	People will be able to get around and access facilities in their local communities;	Carers will be supported to stay mentally and physically well and treated with dignity;	Support carers and empower individuals to do more for themselves;
Improved access to information which allows people to make decision about their own lives;	People will have more choice and control over the health and social care services they use;	Improve end of life care for people living in residential, nursing and extra care housing;	Improve the patient experience of the delivery of care
Thriving and self-reliant communities;	After people are discharged from hospital they will return home to a safe and accessible environment as quickly as possible;	More people die in the place of their choice having received the care appropriate to their needs;	

Integrated Teams and Reablement

Integrated teams available 24 hours a day seven days a week will be contactable through a single access point. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and enhanced rapid response will be provided to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will link with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the primary care and the voluntary sector.

SCHEME REQUIREMENTS:

Integrated Intermediate Care Pathway & flexible use of community based beds

•Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access point;
•Integrated assessments to ensure responsive onward transfer to the most appropriate care setting (including patients own home);
•Intermediate care provision to be provided by professional carers or by a multidisciplinary team of therapists and nurses;
•Intermediate Care beds only to be used for comprehensive assessments, for patients needing 24/7 rehabilitative care;
•Intermediate Care beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand.

Enhanced Rapid Response – supporting acute discharge/preventing readmission

•Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals;
•The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home;
•The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home;
•The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

•Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
•Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
•Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

Enhance Practice Level Teams and Care Coordination

This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

SCHEME REQUIREMENTS:

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community

•Aligned to every GP practice the Practice Level Teams will be accessible seven days a week and out of hours by a broader nursing team. The practice level teams will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;

•The Practice Level Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care, linking with the Integrated discharge team as well as seamless coordination and delivery of End of Life care;

•Patients who require assistance by more than one professional will receive coordinated integrated assessments and care plans. The teams will link with secondary care via the integrated discharge team to report when patients known to the teams have been admitted to secondary care;

•Each Practice Level Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;

•The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;

•The Practice Level Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

The enhanced Practice Level Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

Enhance Primary Care

Integrated community models of care centred on GP practices requires significant change in primary care working patterns. Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities. This will include a hub of practices in every community to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and well-being focus.

SCHEME REQUIREMENTS:

Develop primary care based services with improved access and integrated with other community and specialist services

•GPs to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services, working with at risk patients to avoid crisis and better use of carer support services. This could also include a virtual ward round of at risk patients following hospital discharge;
•GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;
•Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Practice Level Teams as well as stronger links with and signposting to the voluntary sector;
•Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital.
•GP practices to link with the support to care homes pathways to provide more intensive support

Primary care service will support and empower patients and carers to self manage their conditions

•Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
•Primary care and the Practice Level Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
•The Practice Level Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
•Patients will be supported by the Practice level Teams and primary care to inform and take ownership of their care plans this includes electronic sharing of care records with the patient and between health and social care professionals;
•Improved signposting and education will be available to patients through care navigators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health to the right services;
•Develop a Health and social care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.

Enhance support to Care Homes

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory can plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions.

SCHEME REQUIREMENTS:

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes;

•The integrated team can be referred to directly and is aligned to the Practice Level Teams and the Integrated Intermediate Care teams to undertake reviews of care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers;
•The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes;
•Access to specialist services such as Dementia Crisis will be available to support care homes

Integrated Health and Social Housing approaches

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their condition in a safe home environment.

SCHEME REQUIREMENTS:

An integrated approach to local housing and accommodation provision supported by a joint Health and Social Care Accommodation Strategy, to enable more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate place for their needs

•Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
•Responsive timely adaptations to housing;
•Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
•Flexible housing schemes locally;
•Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
•Different types of supported accommodation for those with learning disabilities and mental health needs

Falls prevention

Refresh and revision of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

SCHEME REQUIREMENTS:

A refresh of the local falls pathway linking to the specialist falls and fracture prevention service

•This service will work closely with the Practice Level Teams and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways

•Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;
•Develop an Integrated Falls Response Service to include the ambulance services;
•Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

Success factors and timeframes for delivery

Each of the above schemes together with the wider transformations planned via the Multi-specialty Community Provider has a range of outcome measures to demonstrate success. The key measurements of success are as follows:

•Reduced non-elective admissions
•A&E attendances;
•Reduced hospital admissions and re-admissions for patients with chronic long term conditions and Dementia;
•Reduced length of stay;
•Improved transfers of care;
•Reduced long term placements in residential and nursing home beds;
•Reduced need for long term supported care packages;
•Increase patients returning to previous level of functionality in usual environment;
•Increase levels of patient self management of long term conditions;
•Reduction in falls and secondary falls;
•Reduction in hip fractures;
•Improve patient satisfaction and well-being;
•Increase levels of patients with personal health budgets and integrated budgets;
•Improve health outcomes by better use of prevention services;
•Reduce unnecessary prescribing.

Details of the key milestones, timescales, implications of these changes as well as expected outcomes can be found in the Better Care Fund Plan, which will be available on our website following final ratification.

Alignment with local JSNA and local commissioning plans

The schemes outlined in this plan which have been developed in partnership with social care commissioners. The schemes, along with the CCGs overall commissioning plans, will support addressing the pressing needs identified through the local Joint Strategic Needs Assessment, particularly around the care of people with long term conditions and for those families and individuals supporting them. These health priorities are as follows:

•Being ready to respond to the impact of our aging population;
•Tackling increasing inequalities;
•Improving access to primary care services;
•Managing patients mental health (including Dementia);
•Increasing access to care closer to home;
•Tackle patients' long term conditions;
•Tackle unnecessary and unfair variations in care;
•Improve management and identification of diabetes and CVD;
•Pro-active general practice (smoking, weight, alcohol, health checks etc.);
•Work closely with partners to tackle patients and carer wellbeing.

Implications on the acute sector

The plans align with the delivery of the CCGs strategy, as outlined in section 2a above. The majority of the NHS savings will be realised by the reduced emergency attendances and admissions and a reduction in length of stays within the acute setting and therefore there will be a reduced investment in secondary care.

The plans will not have a negative impact on the CCGs constitutional targets as set out in the Everyone Counts: Planning for Patients 2014/15-2018/19. The plans should enable the delivery of some of these targets, in particular the A&E waiting times and the proportion of older people at home 91 days after discharge from hospital into Reablement / rehabilitation services.

Governance

Local plans will be implemented and monitored using a commissioning project management framework. The delivery of the schemes will be supported by the local Integrated Commissioning Advisory and Support Group which will report progress to the local Health and Well Being Board. Delivery of the plans will ultimately be the responsibility of the CCGs Governing Body.

All defined milestones and outcomes of the plan are monitored at the CCG's Governing Body committee level via the Performance and Delivery Committee and reported for assurance purposes to the Governing Body. The Better Care Fund schemes and metrics are included within the body of the Integrated Quality and Performance Report which is a standing agenda item on the Performance and Delivery Committee.

The committee feeds into the CCG's risk register and any risk to delivery or expected outcomes will be included via output from the committee. Whilst many of the metrics are nationally defined and officially reported annually, proxy measures will be used to monitor them in year, including the Levels of Ambition Tool, Atlas of Variation and SUS data.

Protecting Social Services

The Better Care Fund plans and wider transformation set out a vision for a fully integrated health and social care system. The delivery of these plans will not have an adverse impact the care on the adult social care services and therefore patients and service users eligible for social care services will continue to receive the care they need.

By managing to reable people back to a level of care that means they can manage in the community this will reduce the impact on social care freeing up capacity for the increased demand on services.

Development of a Self Care Strategy will support the prevention agenda which will benefit all organisations as will the development of a joint information advice and guidance strategy which signposts people to the right place.

7 day services to support discharge

The Kent Joint Health and Wellbeing Strategy sets out a number of outcomes aimed at providing seven day health and social care services across the local health economy, for example:

•Ensure all agencies who are working with people most at risk of admission to hospital and long term care have access to anticipatory and advanced care plans and 24/7 crisis response services in order to provide the support needed;
•Ensure all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

All schemes within the local CCG plan require accessible 7 day a week service to support patients being discharged from hospital and prevent unnecessary admissions at weekends.

In South Kent Coast the enhanced multidisciplinary Practice Level Team supported by Integrated Intermediate Care is the main structure for providing post hospital care for any reason and some pre-admission intervention in the community.

Data Sharing

The prime identifier across health and social care in Kent is the NHS number.

NHS

At present all NHS organisations must ensure that a minimum of 95 per cent of all active patient records have an NHS number. The NHS Information Standards Board mandates the use of the NHS number on both general practice and secondary care organisations.

The NHS standard contract states:
"Subject to and in accordance with guidance the provider must ensure that the service user health record includes the service user's verified NHS number. The provider must use the NHS Number as the primary identifier in all clinical correspondence (paper or electronic). The provider must be able to use the NHS Number to identify all activity relating to a service user."

Social Care

A proportion of NHS numbers are held within KCC's Adult Social Care System SWIFT. Monthly batches of client records are sent to the NHS matching service (MACS) and if they can match to a single record on their system they return the NHS number which is uploaded into SWIFT.

The NHS number is predominately used to facilitate the matching of data sets for Year of Care and Risk Stratification, not for correspondence or to undertake client checks, the numbers are too low. We would use name: address and date of birth as the key identifiers at present. Further work will be required to ensure NHS number is used across all correspondence.

KCC achieved approx. 80% matching of records to NHS numbers when we started, improvement to this percentage would need significant additional resource. The MACS service is due to close at some point (no date given yet) so KCC are in the process of transferring to the Personal Demographics Service (PDS).

South Kent Coast CCG, along with all other East Kent CCGs, is committed to using the Medical Interoperability Gateway (MIG) as its preferred solution to interoperability. This is provided by a joint venture between EMIS and INPS Vision, in a company called Healthcare Gateway. Not only will this be within the CCG's Information Technology Strategy, ensuring all new systems utilise this technology, contracts with providers will also require a commitment of their agreement to utilise the MIG. Data sharing (with GPs as the data controllers) have been developed as have governance protocols for the viewing of patient identifiable data and patient consent. In the main consent will be requested at the point of treatment, but protocols are in place for patients who are physically unable to give consent i.e. unconscious.

The project first stage is the integrated use with EKHUFT's A&E and pharmacy departments, stages 2 and 3 will widen this to other providers, as well as allow viewing of provider data at the GP practice site.

Risks	Risk Rating	Mitigating Action
Extensive workforce reconfiguration in the community and within secondary care to ensure the workforce has the required skills and training to deliver all elements of the scheme and 24/7 availability.	High	Each responsible organisation to develop a detailed workforce plan to support delivery of each scheme.
Different skills and training required across multiple professionals and organisations.	High	Training and skills requirements for each scheme to be linked to workforce plan to support the delivery.
Governance of the plans and the delivery of a fully integrated health and social care system should be clinically led and clearly defined.	High	The plans will be governed jointly by the CCG and the local authority using joint metrics. The CCG will report delivery of the plans through existing assurance frameworks.
Communication – need to ensure robust communication with the public and across organisations to ensure people know how to access services within the integrated system to ensure services are used appropriately	High	Robust communication plan to be developed to support delivery of each scheme.
IT systems across services not integrated and therefore do not enable shared care plans between organisations and support integrated outcome measurement and monitoring.	High	Integrated system to support sharing of care plans to be developed as a priority. Integrated performance monitoring and reporting to be enhanced to take into account all schemes.
Transition of service capacity changes to be planned and implemented in stages to prevent destabilising the system.	High	Detailed modelling required to fully understand impact on acute capacity and requirements of community capacity to inform transition over a defined period of time including investment and dis-investment requirements.
Cultural change – significant shift in how systems need to work in the future requirement large culture change	High	Ensure whole health and social care system has shared vision and values to enable the delivery of required changes. Communication with organisations, staff and service users to be included in communication plan.

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To transform the health of people living and working in Thanet, we will work with local people, communities and our partners to deliver high quality services that are patient centred, safe and innovative. We want all our local communities to be ambitious about their own health and to challenge us to commission the best possible care in the best possible environments within our resources.

Strategic goals	Priorities in 2015/16 *The 'What'*	Deliverables and Key Projects *The 'How'*	Key Measures of Success *What will be achieved?*
	Patients receive high quality, equitable, accessible and integrated GP Services through:		**In 2015/16;**
	Improving health information to empower patients	Develop social media and care technologies by March 2016	95% of patients being seen and treated within 4 hours in A&E
	Improving the quality and performance of General Practice based Primary Care	Implement General Practice performance dashboard and actions to address issues by March 2016	
	Improving cost effective prescribing and reducing waste	Supporting safe and effective prescribing and achieving financial balance by March 2016	Meet National Standards for referral to treatment (18 weeks) for secondary care and mental health services
	Developing a Thanet health and social care workforce plan and deliver a workforce development programme	Delivery of identified key development and training programmes by November 2015	
	Supporting collaboration between Practices and encouraging working together in teams	Delivery of uniform high-quality package of care for Over 75s across Thanet using a federated approach by March 2016	Reduction in cost of Continuing Health Care spend
	Focusing on dementia diagnosis and other long term conditions	Delivery of improvement across all national quality and outcome indicators	Reduce the percentage of placements outside of Kent for vulnerable and sick children, young people and adults
	Patients receive high quality, integrated out of hospital care covering physical and mental health through:		
	Commissioning holistic community teams working with groups of Practices in Thanet	Design and implement multi-disciplinary care teams which include Social Care, community nursing, ICT, Physio, KMPT and voluntary organisations as a minimum by March 2016	Financial balance of the Thanet prescribing budget is achieved
	Establishing a Primary Care Hub 24/7 at Queen Elizabeth Queen Mother (QEQM) hospital and 24 hour General Practice support for patients in the community	Implement General Practice and Advance Nurse Practitioner service within A&E at QEQM	Primary Care hub is operational and delivering an increase in patients being seen in the most appropriate setting
Reduce health inequalities	Improving integrated care for people with long term conditions	Support the development and implementation of the Diabetes Single Point of Access pathway, Deep Vein Thrombosis pathway and Rheumatology review by March 2016	
	Improving access to non-acute beds and optimising their use	Optimising appropriate usage of Victoria Unit within Westbrook House by March 2016	Pooling of budgets with KCC Social Care to provide better services in community settings; reducing delayed transfer of care and unscheduled admissions
	Managing effective collaboration between Primary and Secondary Care	Review, develop and implement falls/frailty care pathway in Thanet	
Support healthier choices	Improving integrated care for end of life patients	Implement the core recommendations of the End of Life Strategy in Thanet	
	Patients receive timely, clinically appropriate and high quality care in hospital through:		Delivery of Quality, Innovation, Productivity and Performance (QIPP) schemes in year to drive efficiencies
	Improving the quality and effectiveness of patient transfer of care	By June 2015, undertake a review of integrated discharge team and recommendations for ongoing improvements	
Prevent people from dying prematurely	Managing and supporting East Kent Hospitals University Foundation Trust to deliver 18 week Referral To Treatment, 4 hour A&E, timely cancer services and to minimise unnecessary patient appointments .	Develop and implement local recovery plan to ensure ongoing delivery of Constitutional Targets	Overall improvement in responses to GP patient survey
	Supporting East Kent Hospitals to implement CQC action plan following a CQC inspection which rated the Trust as inadequate	Monitoring of CQC action plan. Collaborative quality improvement to ensure actions are embedded and monitored through contractual meetings	CQC follow up inspection to report Trust as adequate
Commission the right care in the right place by the right health professional	Supporting collaboration between Practices & encouraging working together in teams	Pilot and then roll out, from November 2015, a process by which GPs can receive a more responsive advice and guidance	Achievement of joint provider 2016 CQUINs will ensure better pathways for patients with Diabetes, COPD and over 75 Frailty pathway.
	Re-procuring non-emergency Patient Transport Services	Review the current specification and complete the re-procurement of the non emergency patient transport service, with the new service in place by 2016	
	Managing the optimisation of ambulance services	Review and implement greater efficiency of ambulance services, achieving savings within the financial year	Improved quality and safety for Placements provided by monitoring of key quality indicators and quality visits within contracts
Provide joined up care for patients with long term conditions including dementia	Commissioning effective ambulatory care	Develop a dashboard to monitor and drive improvements of the service by October 2015	Patients reporting good experience of care within commissioned providers
	Patients receive high quality mental health and wellbeing care in the most appropriate setting through:		**Longer-term Ambitions;**
	Commissioning Primary Care Mental Health Specialists (PCMHS) working with all Thanet Practices	Implement specification for Thanet-wide PCMHS by September 2015 with implementation complete by March 2016	Thanet residents are empowered to manage their own wellbeing and are able to access services that deliver Value for Money
	Minimising out of area treatment for Thanet Mental Health patients	Review mechanism for and management of placements to drive efficiencies by June 2015	
	Improving support for people with Eating Disorders	Review current pathway and interventions and implement new service for Eating Disorders by March 2016	Shift towards prevention & earlier intervention with Thanet residents choosing to access care in community and primary settings
	Improving access to and services for those with personality disorders	Review of service provided by Kent and Medway Partnership Trust and evaluate effectiveness against best practice models	
	Improving access to Autistic Spectrum Condition/Attention Deficit Hyperactivity Disorder services	Develop and support implementation of all age Kent pathway for Neurodevelopmental conditions by March 2016	Embedding of Crisis Care Concordat and Parity of Esteem approaches for mental health
	Improving transition from children to adult mental health services	Joint transition CQUIN between SPFT and KMPT	Timely and safe transfer from children to adult mental health services
	Assessing the effectiveness of crisis support and develop an improved service specification	Review current service provided by Kent and Medway Partnership Trust and develop future options by September 2015	Reduction in health inequalities and improved consistency in the delivery of clinical services
	To ensure high quality children's services through:		
	Ensure adequate paediatric staff within A and E. CQC reported current paediatric workforce not sufficient	Monitoring of CQC action plan. Collaborative quality improvement to ensure actions are embedded and monitored through contractual meetings	CQC Inspection follow up inspection to report Trust as having appropriate skilled paediatric workforce
	Reducing the number of Thanet children going to A&E unnecessarily	Review pathways of top 10 acute conditions. Develop and implement to support children and families accessing appropriate support outside of secondary care by March 2016	Children's voice threaded and heard through all work streams and children reporting good experience of care
	Ensuring an improved Child and Adolescent Mental Health Service specification represents the needs of Thanet children	Co-produce a robust, costed, needs-led CAMHS model and specification by August 2015	
	Establishing Looked After Children expertise in the CCG to improve health support for vulnerable children (including disabled children) and their families in Thanet	Develop and implement a Vulnerable Children Action Plan owned by the Thanet Health and Wellbeing Board by September 2015	

Rigorous financial planning and investment to deliver the optimum level of health care in Thanet

Ensure quality at the beginning of commissioning cycle and robust quality monitoring to ensure high quality, safe effective care for all Thanet residents

Addressing health inequalities in all of our planning and delivery	**Delivering NHS Constitutional Standards**
Enablers: Quality and safety; contracting and performance management; partnership working; engagement and communication; organisational development, workforce development, Information Management and Technology	
Better Care Fund; Pooled budgets with KCC Social care to deliver more effective and efficient services	**Partnerships:** Patients and carers, providers, KCC, Thanet District Council, NHS England and the voluntary community sector

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NHS Swale CCG

Annual Operating Plan 2015/16 (Year two)

The Executive Summary

Introduction

Our Five Year Strategy and Two Year Operational Plan identify the key priorities for the period of 2014 to 2019. It incorporates the views of the public and our providers, and is in line with the Kent Health and Wellbeing Strategy to which we have been an integral part of in terms of design and content.

The CCG Vision is to commission health services that meet the needs of the Swale population, provide value for money, address health inequalities, and improve health outcomes, to enable the population of Swale to lead healthier and more independent lives.

This vision cannot be delivered in isolation by the CCG, and requires a whole system approach to the delivery of care. The proposed commissioning intentions outlined within this plan, therefore, reflect the joint view and intentions from the Health Economy developed through partnership forums and clinically led workshops with providers.

Our Aim is to improve integrated care in the community that enables our GP members to be able to support, particularly, our older and more vulnerable patients effectively, both proactively and when a patient is in an acute crisis

Key to delivering this aim is our Better Care Fund plan, which has been developed with our partners (providers, Local Borough Council and Kent County Council) and patients. Elements of this plan have been introduced within 2014/15 to test out approaches to integrated working, such as the Integrated Primary Care Teams. We have established joint governance arrangements with our local partners and patients to oversee the implementation of these plans, and ensure ongoing commitment to commission and deliver care in a more integrated way.

The Executive Programme Board forms part of this joint governance structure and through this we have elicited a whole system agreement to reduce emergency admissions by providing such integrated care that wraps around the patient and supports GPs to proactively identify and manage vulnerable patients. Thus, enabling them to remain as independent as possible.

The Plan on the Page diagram (2014-2019) (Appendix A) provides a summary of our five year strategy and high level details of the top priorities that we will be focusing on to deliver improved health outcomes for our patients

Transformational change

The need for transformational, system wide change is clearly recognised, and as such, is a key element of the CCG plans going forward.

Our aim is to create a long-term sustainable health care system across Swale whereby primary, community, mental health and urgent care (including SECAMb, NHS111 and Out of Hours) work seamlessly together with the local authority, Borough Council, third sector and voluntary providers to deliver the health and well-being priorities for local people and their communities including sub-acute care delivered by specialists employed by the community or through an outreached capacity by a number of acute providers. At its heart it combines GP services with wider community-based services including social care, district nursing, mental health, pharmacy, step-down beds, reablement and domiciliary care services.

The CCG and local GPs are actively pursuing true integrated primary care (through our Integrated Primary Care Teams – IPCTs) and want to expand on this model by exploring further alliances with community and social care providers and particularly South East Coast Ambulance Service to provide extended and integrated primary care and sub-acute care services across Sittingbourne and the Isle of Sheppey.

Through doing the above, we want to ensure that health and healthy living is a priority in the redesign of urgent care, community and primary care services, particularly using our community hospitals as central hubs. We have a unique opportunity, with Kent County Council (KCC), to contribute to the design of good living space within the proposed developments laid down within the KCC estates strategy. In addition, there is a unique opportunity within Sheppey hospital to design a health and social care hub with the facility for full and enhanced diagnostics, delivery of ambulatory and sub-acute care and a range of planned and urgent extended primary care services, with health and wellbeing at the fore and new clinical delivery designed from scratch. This sits well with the changes in our demographics and focus on prevention and the reduction of health inequalities. And with our ageing population, we want to preserve people in their communities as long as possible, ensuring they are self-reliant and are able to access health and social care advice and information as easily as possible; but ensuring that care when needed is provided in the lowest intensity environment and as locally as possible. We have applied to become a **Vanguard Pilot** as we believe this support us in delivering at pace and extending and enhancing the strong collaborative partnership that already exists across this community.

NHS Swale has developed strong collaborative arrangements across acute and primary care in particular, and with the health economy, social care, the local authority and Borough Councils. To this end, the local health economy commissioned the Kings Fund to complete a piece of work during 13/14 as part of the two and five year planning process. This work focused on what services would be required over a 5-year period to meet the changing needs within Swale based on projected demographics and effectiveness of prevention interventions, etc.

It was clear from this piece of whole system work that efficiencies can be made through reconfiguring the way care is delivered, with a greater focus on more robust primary care, and stronger involvement of specialist care (hospitals without walls) within the community. Furthermore, efficiencies can and should be made in the way that community health and social care operate to provide more sub-acute care, in particular, within community estates and integrated care within peoples' homes. By following through the recommendations, the Kings Fund believes that the system and acute hospital could absorb and manage the expanding elderly population

The CCG has already made significant steps towards progressing integrated care services and by April 2016 will have;

- Enhance the Integrated Discharge Team model and have a working and fully implemented network of integrated primary care teams in place across Swale. These will include district nursing, mental health services, social care and domiciliary care.
- completed an adult community services review based on a lead provider model, and by April 2016 expect to be in the process of implementing any changes arising from the review, with a specific focus on the integration model;
- Procured a new urgent care model that combines out of hours, minor injury units, walk-in centres and NHS 111services and integrates fully with primary care and ambulance service provision.

NHS Swale has a good track record of developing and delivering new ways of working. This has resulted in the establishment of joint governance structures with the local authority such as the joint strategic and operational commissioning group, which reports directly into the CCG and Local Authority systems. This group drives clinical innovation, reviews respective plans for delivery and has been fundamental in the design and introduction of care pathways and the development of the Integrated Discharge Team and community based Integrated Primary Care Teams around general practice.

In addition to the above, the CCG has with its North Kent CCG partners (NHS Dartford, Gravesham & Swanley CCG and NHS Medway CCG) developed the **North Kent Education, Research and Innovation Hub (ERIH**), which brings together Health Education England, local academic partners, professional bodies and clinical leaders. The purpose of this forum is to look at innovative approaches to recruitment and workforce delivery to meet current requirements and support aspiring models, to stimulate local research and bring together joint strategies to education and training. This forum is already forging strong partnerships with the Royal Colleges and NHS Employers. Outcomes so far have been;

- An increase in the number of training practices within Swale: in the last 12 months we have moved from having no training practices in terms of medical GP trainees, to having four larger practices across Sheppey and Sittingbourne now registered and validated to take on trainees.
- The ERIH has also resulted in the appointment of practice nurse tutors to provide opportunities to train both student and post graduate nurses in primary care, and
- Placement of paramedics within primary care including the use of local GPs in paramedic training.

The forum has also supported practices in delivering health care research and can provide a vehicle for the evaluation of any emerging models. Four practices are working with local universities in conducting research relating to the commissioned alcohol and benzodiazepine reduction schemes within Swale.

Key Commissioning intentions (including Forward view into action focus on prevention)

NHS Swale CCG has strong relationships with public health and recognises the unique value that the science of public health can bring. Given the modelling required and level of health inequalities within the community, the CCG has agreed to appoint its own public health consultant, not to take over the statutory role that is provided within the local authority, but to bring a wider science and systematic approach to the planning process and management of health prevention. The post is supported and has been approved by the Faculty of Public Health. An interim has been in post for the last year to test out this approach whilst the CCG has gone through the Faculty approval process. This resource has significantly contributed to much richer, standardised data and the evaluation of schemes and programmes. The post acts as an effective bridge between general practice and the local authority in terms of design of preventative strategies and in the critique and evaluation of plans. (Note: Key public health programmes are identified in the refreshed Operating Plan)

Commissioning intentions 2015/16

The plan on the page (*Appendix A)* identifies the key priorities and plans for the CCG for 15/16. This builds on the programmes and projects developed in 2014/15. The CCG's transformation plans (see above) identify the key areas of focus and the priority programmed that we will be working on. We believe that parity of esteem is important and we will continue to implement and develop support for patients (both children and adults) who suffer from mental health illness. Key areas for the additional mental health investment include:

- Investing in Liaison Psychiatry at Medway FT Hospital A&E - £119k
- ASD investment - £35k
- Armed Forces contract investment related to Veteran mental health - £5k.
- Mental Health Placements – expected increase – £150k
- ADHD Satellite Clinic - £174k

The balance will be used for out of area placements or further investment in services as identified. Please see Appendix D for the commissioning intention programme summaries.

Finance Context and delivering value *(please refer to the Finance section in the 2year Operating Plan for the full detail)*

The CCG has now revised its financial plan in line with changes to resource allocation and expenditure demands. The CCG has received an additional £3.2m funding for distance from target that was not in the plan last year. This will be used for the transformational changes and investment that the CCG is under taking, this includes;

- Adult Community Services Review
- Urgent Care Review
- Better Care Fund
- Patient Transport tender (transforming patient services)
- Investment in Mental Health

The CCG has also received 1.4% GDP growth of £1.7m, winter resilience funding of £0.7m and the Better Care Fund transfer of £2.1m. The CCG has a non-recurrent return of surplus of £1.4m. The CCG proposes to use Winter Resilience to fund the Integrated Discharge Team.

Allocation 15-16	£000
Recurrent Baseline 14-15	123,252
1.4% Growth	1,726
Post M7 Allocation (Spec Comm)	300
Post M7 Allocation (HIV Drugs)	209
Winter Resilience	670
Distance from Target	3,229
Better Care Fund	2,067
Total Programme Allocation	**131,453**
Running Costs	2,374
Total Recurrent Allocation	**133,827**
Return of Surplus	1,426
Return of CHC Risk Pool	294
Total Allocation	**135,547**

QIPP 2015/16

The largest programmes in terms of financial gain are:

Swale QIPP by Programme 2015/16	Saving £000	Investment £000	Planned Net Saving £000
Urgent Care	(954.2)	172.2	(782.0)
GP prescribing	(587.0)	116.0	(471.0)
Planned Care	(503.1)	171.8	(331.3)
Mental Health	(451.0)	196.5	(254.5)
LTC	(222.6)	0.0	(222.6)
Primary Care/Health Inequalities	(130.9)	0.0	(130.9)
Continuing Care	(125.0)	0.0	(125.0)
Other	(101.6)	119.0	17.4
	(3,075.4)	**775.4**	**(2,300.0)**

The CCG is continuing with its integrated discharge team and integrated primary care teams. These are expected to prevent A&E admission and non-elective admission as patients are managed within the community. The Better Care Fund will also focus on health services working with social care. *(Appendix B provides further detail on the key commissioning projects linked to the programme areas)*

Financial Risks

There are a number of risks associated with the indicative Budget for 2015/16, the key risks being:

1. The PbR tariff for 15/16 has not yet been finalised, and providers need to confirm which they would prefer to use by the 4th March, currently all contract assumptions are on 14/15 tariffs adjusted for growth and deflation.
2. The NHS Standard Contract has not yet been issued. This will put pressure on the contract timetable, contracts are due to be signed on 31st March 2015.

3. Routine Seasonal Resilience is now included in recurrent allocations, but that for Ambulance Services is not and is held centrally. The cost of this is shown as a mitigated risk in the planning forms.

Triangulation of Planning Returns

Key planning assumptions and operational plans have been applied consistently across the various planning submissions and their relevant sub-elements. However adjustments to finance and activity plans will not always be in direct proportion as; not all finance changes will have an associated activity impact; some activity related changes will not be measurable in the templates e.g. excess bed days and switches between long and short stay admissions; the activity returns themselves are related to General and Acute activity and so Mental Health and Community providers activity is excluded; activity for RTT, and other NHS Constitutional measures, does not match exactly to contracted elective activity which would include planned treatments, RTT exclusions etc.

Impact on Growth - Growth has been applied consistently across all relevant areas for 2015/16 at 1.5%, combining demographic and demand impact. This has been applied to forecasted activity, finance, referral and acute activity based NHS Constitution measure e.g. RTT and diagnostics.

Application of QIPP Schemes - The CCG's plans for QIPP schemes are at an individual project level, detailing planned implementation and delivery at a Provider, point of delivery and specialty level. Development of these schemes is logged centrally on one document and includes both finance and activity impacts on phased basis. Whilst these are continually evolving documents, a point in time extract has been used for the planning documents and as such financial and activity impacts will be consistent in the templates. In addition the QIPP documents record whether schemes have an associated GP referral impact. Where schemes are highlighted as such the associated referral activity has been adjusted down within referral activity templates.

Activity Reconciliation with UNIFY Submission - As previously stated contracted activity does not correlate to NHS Constitution activity denominator levels. However planning assumptions have been incorporated into the trajectories included within the UNIFY submission. In addition where the CCG has highlighted the potential need for recovery plans to achieve Constitution measures this will be incorporated into the associated activity and finance templates in future iterations once the full impact is known.

Governance and Delivery in 2014/15

Collaborative Boards at Executive and clinical operational levels have existed for some time (reference: Governance section of the Swale Five year Commissioning Strategy). This has resulted in a wide range of joint health and social care programmes focusing on;

- the reduction of health inequalities through systematically targeted prevention strategies,
- improvements in primary care mental health services and a real focus on dementia,
- targeted support for the frail elderly and patients with long term conditions.

Such schemes have demonstrated tangible benefits over the last year in particular both in terms of improved care outcomes for patients, and improved performance delivery. These include:

- A reduction in the number of patients within our community hospitals being placed there whilst awaiting permanent care; a reduction from 66% of patients placed into community services with no rehabilitative need, to less than 30% awaiting permanent care following rehabilitation;
- Since Jan 2014, no patient has been admitted into long term care from the acute trust and 95% of patients have been successfully discharged to their original place of residence;
- A reduction in the number of duplicate care plans and services through the introduction of integrated teams;
- A corresponding increase in spend for re-ablement;
- An increase in the number of dementia patients being discharged from A&E back to their normal place of residency with health and enablement support and voluntary care support from the Alzheimer's and Dementia Support Service;
- A health system where both commissioners and the majority of its providers have delivered financial balance in recent years, but face a more uncertain future without new models of care

Quality and Safety

Quality and safety remains at the heart of the CCG. Linking across providers to improve the impact on the quality of care and the effect on patient safety and experience will be fundamental to the integration of health and social care going forward. As recommendations from the Francis, Berwick and Winterbourne reviews become mainstreamed and embedded as business as usual within organisations, the ongoing oversight of the actions will remain an essential part of the continuing monitoring with providers and for the CCG as an NHS organisation in its own right.

The CCG works with commissioned providers to monitor and assure the quality and safety of services and outcomes for patient experience. Within Swale these providers are South East Coast Ambulance Service (SECamb) and Kent Community Healthcare Trust (KCHT). The CCG also works closely with Medway CCG in relation to quality and safety at Medway Foundation Trust (MFT) and with Dartford Gravesham & Swanley (DG&S) CCG in relation to Kent and Medway Partnership Trust (KMPT). Across these providers the main focus areas include:

- **SECamb** - Issues in relation to compliance with mandatory training targets and uptake of key workforce measures such as appraisal are an area of focus with the organisation.
- **KCHT** - The CCG is working to gain greater assurance around Looked After Children (LAC) arrangements with the trust.
- **MFT** - There are ongoing quality and safety concerns across the organisation. The trust is not meeting constitutional targets particularly in relation to Mixed sex accommodation and HCAI.
- **KMPT** - There are ongoing concerns relating to crisis management workforce as highlighted from deep dive into the service last year. This was also reflected at the recent CQC thematic review. The Trust are to have their CQC chief inspector of hospitals inspection in March.

Swale CCG has arrangements in place with DG&S CCG and Medway CCG to collaborate on the functions of the Quality and Safety team which includes safeguarding children and adults. Swale CCG also hosts the CCG's LAC service for the whole of Kent and Medway and the Child Death service for Kent (excluding Medway).

Further improvements in the reduction of Healthcare Associated Infections and learning from incidents of HCAI across Acute, Community and Mental Health, Primary and Social care will further improve the reductions achieved to date.

NHS Constitution performance

As at December 2014 Swale CCG has failed to meet the following NHS Constitution targets on a year to date basis.

- Referral to treatment (admitted patients within 18 weeks – YTD (Dec) performance 88.17% and Q3 performance 83.5%
- Emergency access – A&E 4 hour waits – YTD (Dec) performance 83.74% and Q3 81.43%
- Cancer – two week wait from Urgent referral – YTD (Dec) performance 92.79% achieved at Q3 at 95.35%
- Cancer – 62 day urgent referral to first treatment – YTD (Dec) performance 77.70% and Q3 81.03%
- Ambulance response (Trust level) R2 performance YTD (Jan) performance is 74.3%

Appendix C provides more detail on the reasons for the deterioration, the key actions being taken now, with providers, to address the performance and what performance we expect for 2015/16.

BCF level of ambition for reducing NEL admissions

Fundamentally, we believe that the Better Care Fund should be used for genuine transformation of the health and social care system in North Kent, not to plug a gap in the social care or health budgets brought about by increasing demand and reducing budgets. This transformation is not just about reducing admissions to hospital, but rather about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary/community/mental health/social care, with the goal of living as independently as possible.

Swale, along with the other 6 Kent based CCGs, has been awarded Pioneer status with Kent County Council - one of 14 Pioneer sites in the country. The Kent Better Care Fund (BCF) Plan has been approved and all conditions have now been satisfied. The North Kent submission has been noted as an area of good practice based on the success and degree of integrated working to date.

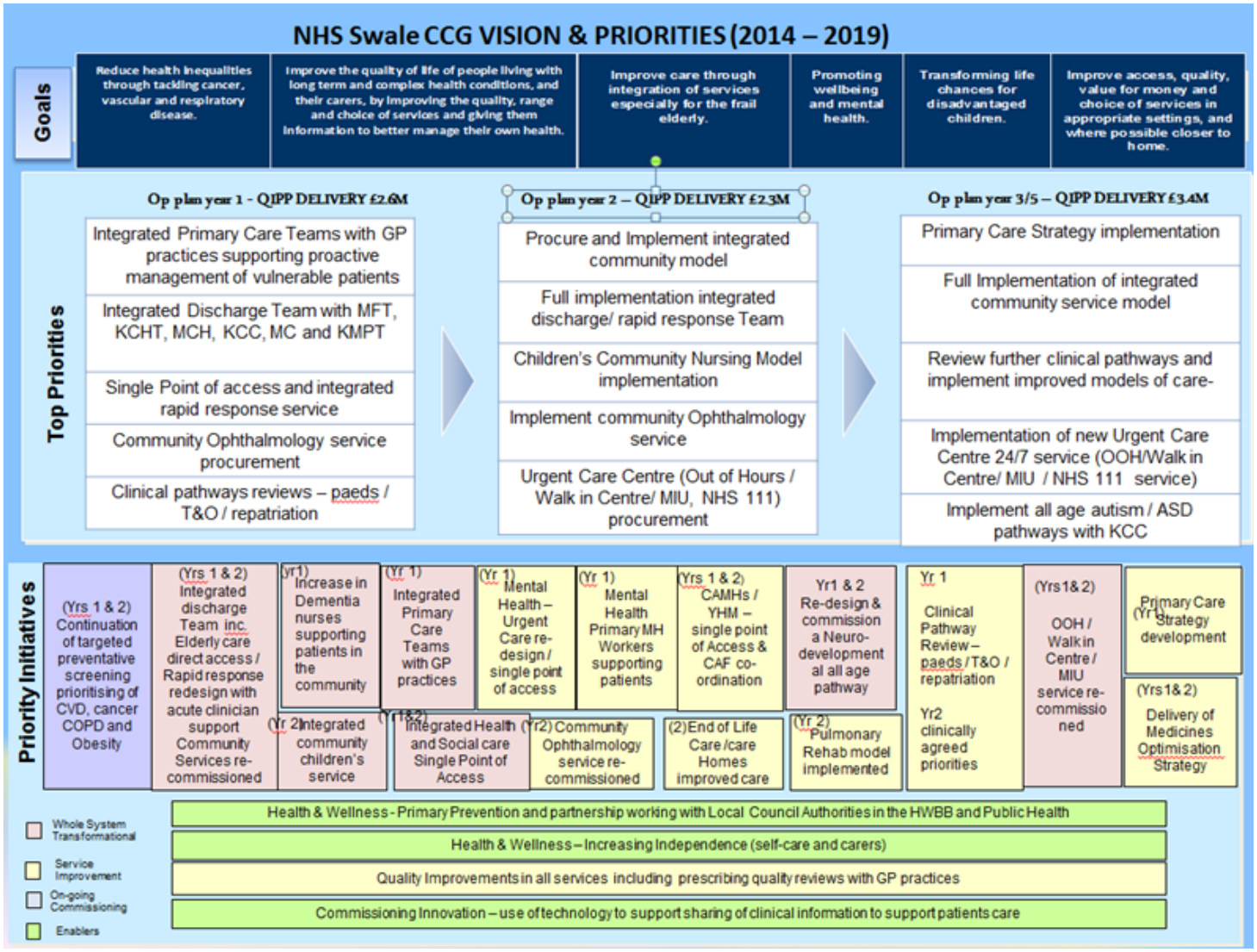
The Kent HWBB have agreed with all Kent based CCGs that the original ambition of 3.5% reduction in NEL admissions is not achievable due to the current significant demand on the acute system and Swale CCG has agreed a 0.8% NEL admission reduction target as part of the BCF (*Reference: Swale Strategic Commissioning strategy for BCF investment)*

Overview of CCG's internal operating plan assurance process

The CCG has developed a clear governance structure for the review and development of whole system, health economy plans. The Executive Programme Board Structure, for example, was developed for this purpose and this links into to a wider governance structure that supports the operationalisation of agreed plans. CCG plans and provider plans are coterminous. All providers have been equal partners in the redesign which was jointly commissioned through the Kings Fund and Oaks Group and through the development of the Better Care Fund plans.

The operating plan describes our CCG Governance processes.

Appendix A – NHS Swale CCG Plan on a Page 2014 -19



Appendix B – Details of the QIPP key projects.

QIPP Programme Area	Point of Delivery impacted	15/16 Planned Activity Changes	Total planned 15/16 finance reduction £000	Total Per Point of Delivery	Total per QIPP Area	Project Name
Urgent Care	Accident and Emergency	-129	-£13			Falls Prevention
Urgent Care	Accident and Emergency	-300	-£16			North Kent Review of Urgent and Emergency Services
Urgent Care	Accident and Emergency	-7	-£1			Staying Put
Urgent Care	Accident and Emergency	-156				Dementia crisis and carers short breaks
				-£31		
Urgent Care	Long Stay Emergency Admission	-43	-£108			Befriending Home from Hospital Service (Age UK)
Urgent Care	Long Stay Emergency Admission	-52	-£134			Admission avoidance and facilitated discharge schemes
Urgent Care	Long Stay Emergency Admission	-120				Dementia crisis and carers short breaks
Urgent Care	Long Stay Emergency Admission	-60	-£150			Impact of primary care schemes (ie: iPCTs, MDTs)
Urgent Care	Long Stay Emergency Admission	-15	-£33			Improved end of life care
Urgent Care	Long Stay Emergency Admission	-7	-£35			Staying Put
Urgent Care	Long Stay Emergency Admission	-45	-£103			Support to Care Homes (Nursing and Residential)
Urgent Care	Long Stay Emergency Admission	-24	-£64			Teletechnology in care homes
Urgent Care	Long Stay Emergency Admission	-50	-£117			The Frailty Pathway
				-£744		
Urgent Care	Long Stay Emergency Excess bed days	-396	-£82			Dementia crisis and carers short breaks
				-£82		
Urgent Care	See&Convey	-129	-£22			Falls Prevention
				-£22		
Urgent Care	See&Treat	129	£14			Falls Prevention
				£14		
Urgent Care	Short Stay Emergency Admission	-27	-£61			Admission avoidance and facilitated discharge schemes
Urgent Care	Short Stay Emergency Admission	-20	-£14			Support to Care Homes (Nursing and Residential)
				-£75		
Urgent Care	Other		£9			Befriending Home from Hospital Service (Age UK)
Urgent Care	Other		£60			Improved end of life care
Urgent Care	Other		£85			Staying Put
Urgent Care	Other		£2			Support to Care Homes (Nursing and Residential)
				£155		
Total Urgent Care					**-£783**	
GP prescribing	GP practice		-£11			GP IT support system
GP prescribing	GP practice		-£133			Practice Work
GP prescribing	GP practice		-£367			Prescribing incentive Scheme
GP prescribing	GP practice		£6			Waste reduction project
				-£505		
GP prescribing	Pharmacies		£34			Sleep clinic to support children at MFT
				£34		
Total Prescribing					**-£471**	

QIPP Programme Area	Point of Delivery impacted	15/16 Planned Activity Changes	Total planned 15/16 finance reduction £000	Total Per Point of Delivery	Total per QIPP Area	Project Name
Planned Care	Attendances - community	594	£24			Community Ophthalmology Service
				£24		
Planned Care	Direct Access Pathology		-£300			Pathology Review
				-£300		
Planned Care	Outpatient Bundle	1,810	£172			Level 3 Dermatology Service
				£172		
Planned Care	Outpatient First Single Professional	-680	-£80			Level 3 Dermatology Service
Planned Care	Outpatient First Single Professional	-136	-£16			Community Ophthalmology Service
Planned Care	Outpatient First Single Professional	1,508				MTW OP Project
				-£96		
Planned Care	Outpatient Follow-up Outpatient Procedure	-333	-£43			Level 3 Dermatology Service
				-£43		
Planned Care	Outpatient Follow-up Single Professional	-797	-£57			Level 3 Dermatology Service
Planned Care	Outpatient Follow-up Single Professional		-£30			Community Ophthalmology Service
				-£87		
Total Planned Care					**-£330**	
Mental Health	Accident and Emergency	-100	-£9			Peer Support Group
				-£9		
Mental Health	Block - community	-2	-£22			Peer Support Group
Mental Health	Block - community		£15			Peer Support Group
Mental Health	Block - community	-28	-£65			Primary Care Mental Health Specialists
				-£72		
Mental Health	Placements		-£125			MH Placement Reduction
				-£125		
Mental Health	Short Stay Emergency Admission	-180	-£111			Liaison Psychiatry
				-£111		
Mental Health		0	£13			Primary Care Mental Health Specialists
Mental Health		0	£50			Primary Care Mental Health Specialists
				£63		
Total Mental Health					**-£255**	
Primary Care/Health Inequalities	Long Stay Emergency Admission	-42	-£95			Health Inequalities - projects
				-£95		
Primary Care/Health Inequalities	Short Stay Emergency Admission	-21	-£15			Health Inequalities - projects
				-£15		
Primary Care/Health Inequalities			-£20			GP Care Hub/Extended Hours - Placeholder
				-£20		
Total Primary Care / Health Inequalities					**-£130**	
Continuing Care	Placements		-£125			CHC Placement Reduction
				-£125		
Total Continuing Care					**-£125**	
Integrated	Block - community	-100	-£2			Primary care based memory assessment services
				-£2		
Total Integrated					**-£2**	
Other			-£204			Various
				-£203		
Total Integrated					**-£203**	
Total QIPP					**-£2,300**	

Appendix C – NHS Swale CCG Constitutional Performance and actions

High Risk Area : A&E 4 Hour wait	
Current position	The standard has been consistently failed throughout 2014/15 due to the performance at Medway NHS Foundation Trust (MFT).
Diagnosis	As previously reported there are long standing cultural issues of poor clinical leadership and engagement and a lack of performance management at the hospital; poor management of flow through the hospital with no differentiation between short and long stay patients; and a lack of effective process for both complex and non-complex discharge. MFT remains in special measures and rated as 'inadequate' by the CQC.
Action	At a national/regional level there has been oversight through Monitor as the regulator of the Trust. NHS England has also held a number of Risk Summits with MFT, regulators, commissioners and other partners. At a local level whole system challenge and oversight is in place through the Medway and Swale Executive programme Board supported by a number of plans. A refocused whole system plan was agreed following a Star Chamber meeting with NHSE and Monitor; this included a revised trajectory to achieve 95% by March 2015. The Trust now has a single 18 month plan which incorporates all previous action plans and requirements, running through to April 2016. . The significant increase in admissions in 2014/15 (47% to January), specifically December and January, has had an impact on the recovery plan. Some of this increase would have been increased acuity but the continued internal operational issues will also be a large factor. There was not the same increase in overall attendances – with only an 8.2% increase April to January. As part of the ORCP the Oak Group were commissioned to complete an Audit of admissions and beds/stays (Jan 2015). This audit highlighted that 26% of admissions and 54% of continuing stay days were non-qualified and could have been provided at an alternative level of care. *It should however be highlighted that his was a point in time audit and there should be no assumption made that 26% of admissions could be instantly avoided or all continuing care stays could be reduced.* Immediate action was agreed at the Executive Programme Board (EPB /SRG) to commission the Oak Group STREAM model within ED for 4 months (from March 2015). This is focused on understanding on a 'live' basis the non-qualified admissions and also understanding connectivity to community health and social care pathways, specifically response times and service needs in terms of avoiding admissions and supporting people at home/other community setting. This will provide the system with real time intelligence and feed into the wider executive discussions established to review themes in order to identify and agree changes that can be made.
Trajectory for 15/16	The Trust is working to achieve 95% in March with a number of plans coming on line 2 March – including STREAM, Geriatrician of the day and changes to wards with two to focus on lower acuity/Medically fit for discharge to support efficiency of Trust and IDT processes. The CCG will monitor progress during March (daily oversight on performance) but at this time is expecting the 95% standard to be achieved consistently during 2015/16, despite the current limited performance improvement. This will be reviewed during March and if required improvement to headline performance is not seen then a revised trajectory and recovery plan will be agreed for 15/16.
Investment	No additional investment is built into the plan , all activity paid through PbR.

Ambulance Cat A Red 1 and Red 2	
Current position	For 2014/15 it is expected that the Red 1 target will be met, but Red 2 will marginally fail at over 74% achievement for the full year although it has achieved in each month since October 2015, with the exception of December and performance should be maintained through the remainder of the financial year and into 2015/16. This standard is reported at a Kent and Medway level.
Diagnosis	Hospital pressures continue to be the major problem for SECAmb in terms of the hours lost from crews waiting at hospitals. MFT has had one of the highest '"lost hours" due to handover delays in 2014/15.
Action	As part of the revised system improvement plan trajectories have been agreed for eliminating over 60 minute handovers, improving the number of handovers within 30 minutes and reducing the number of hours lost from crews waiting at the hospital. There is evidence that the planned schemes in MFT are starting to positively impact as in January and February there has been an improvement in all areas which has contributed to a an improvement in the local SECAmb response times as the ambulance crews are released back on the road much sooner. Further improvements are required.
Trajectory for 15/16	The CCG is planning that Red 1 and 2 targets will be achieved in 2015/16. This will be further supported by a continued focus on handover performance through the MFT contract.
Investment	No specific investment. Contract negotiations focusing on totality of activity.

High Risk Area: 18 week referral to treatment (RTT)for admitted pathways	
Current position	Due to the agreed suspension of RTT reporting at Medway NHS Foundation Trust the reported figures at CCG level from December 2014 exclude all activity treated at MFT and is therefore not a true reflection of the CCGs actual performance. On average Medway NHS Foundation Trust would generally contribute two thirds of the CCG overall activity.
Diagnosis	Agreement was reached with Monitor that RTT reporting would be suspended until 2015/16 to allow the Trust to complete a data quality review which would also support the move to a new PAS system in February 2015. (Note – PAS implementation successful)
Action	Whilst reporting is suspended the CCG has maintained oversight of RTT activity. As part of the additional RTT funding designed to reduce the number of patients who have waited more than 18 weeks and have not yet been treated (referred to as 'backlog'), it had been anticipated that MFT would start to treat a proportion of the backlog activity however due to the high demand on non-elective services (ref A&E narrative above) in December and January the Trust suspended the elective activity which has resulted in a further significant increase in the backlog. To date limited off site activity has occurred although the Trust are planning to offer off site choice to patients for the Independent Sector during March and into 2015/16. Any additional activity in March will not be sufficient to reduce the backlog to a sustainable position by 1 April 2015 but we expect continued off-siting to deliver a sustainable position by the end of Q2.
Trajectory for 15/16	The CCG is currently assessing the position with MFT and is awaiting the most up to date backlog information (following an agreed reporting suspension over PAS go live) in order to model the activity and RTT performance. Given the significance of the backlog the CCG is working to agree a recovery plan, aligned to a clear reporting and performance management framework, with MFT for the first 6 months of 2014/15.
Investment	Additional Investment will be required and contract plans will be adapted to reflect the required reduction in the backlog.

Cancer Access Targets • **Cancer - two week wait from urgent referral for breast symptoms** • **Cancer – 62 day wait from referral to first treatment** • **Cancer – 62 day wait from referral from screening to first treatment.**	
Current position	• Cancer two week wait from urgent referral – performance for the year to date (to dec) is 92.79% and 95.35% for quarter 3 • Cancer - two week wait for breast symptom referral - performance for the year to date (to dec) is 93.28% and 88.49% for quarter 3. • Cancer - 62 day urgent referral to first treatment - performance for the year to date is 77.70% and for quarter 3 it is 81.03%
Diagnosis	Data Quality, process and recording issues identified. (See below)
Action	Assurance has been sought from MFT for all cancer targets but specifically two week wait (all and breast symptoms) and 62 day wait pathways. The response to the contract query regarding two week waits highlighted that the breach reasons had been incorrectly recorded. There are however acknowledged issues regarding data quality following a review by PricewaterhouseCoopers (PwC) and the Trust are not therefore able to give complete assurance regarding delivery of all standards. PwC are now undertaking a further piece of work to review all current recording and reporting processes and the CCG have requested the Terms of Reference for the review and regular updates will be provided to the CCG. Breaches of the operational standards for Cancer Waiting Times will continue to be raised in the Provider performance letter and the contract query is on hold until the outcomes of the PwC review. The CCG is also requesting a review of patient notes
Trajectory for 15/16	To be confirmed following PwC review but early information would suggest recovery plan for Q1 (minimum) will be required. Being discusses at contract performance meeting on 4th March 2015.
Investment	No specific investment requirements.

Appendix D – Programme Summaries

Programme Area: Urgent Care

Objective:

- To review urgent and emergency care services across North Kent to shape and structure future model of care which provides highly responsive, effective and personalised services.
- To achieve a reduction in the number of A&E attendances and non-elective short and long stay admissions by supporting people to manage their condition in the community
- To reduce the number of ambulance conveyances by appropriate use of alternative pathways and services in the community.

Key Drivers for Change:

- Growth in the elderly population
- The Oaks Group capacity work supporting initiatives for patients to be looked after in the community with appropriate support from health and social care services
- The need to provide support to enable people to die at home should they prefer to
- NHS Outcomes Framework and Keogh Mortality Review 2013 – The Review identified areas with scope for improvement within the Trust which the urgent care programme supports
- The NHS Five Year Forward View – supporting the redesign of urgent and emergency care services to integrate between A&E departments, GP out of hours services, urgent care centres, NHS 111 and ambulance services

What did our providers and GPs tell us?

- Issues relating to access of acute services, effective discharge of patients, lack of nursing home beds, inappropriate attendances at A&E, acuity of patients presenting at A&E, poor quality discharge information
- Impact of urgent care pressures on the provision of elective care at the Acute Trust

What did our patients and local population tell us?

- Patients want clarity of services with easy and timely access
- They want alternatives to hospital and want to remain living independently within their homes as far as possible with the appropriate support
- They want to be able to make informed choices and be supported to plan their end of life care

Key Projects and milestones
(Continuation of projects for 14/15

- **Support to care homes:** Dedicated nursing and residential care home community matrons providing hands on care and out of hours advice and guidance. Working in partnership with Kent County Council, a review of nursing homes will be undertaken to understand the current provision and future need specifically in Sheppey.
- **Improved end of life care:** Through the identification of patients nearing the end of life, supporting them with advanced care planning. Agreed advanced care plans will be in place and the My Wishes End of Life Register will be available to record patients care plans.
- **Handypersons scheme**: Continuing the partnership with Swale Borough Council to support Swale residents (over the age of 65) to live safely and independently within their homes.
- **Reduction in A&E attendances:** A range of projects including reviewing the SECAmb pathways and minor injury units, ensuring optimum use in Swale. Rolling out localised 'Chose Well' media campaigns to raise awareness of alternative services to A&E supported by the Health Help Now website and mobile app.
- **Integrated Health and Social Care Admissions Avoidance and Discharge Teams/Integrated Primary Care Teams:** Continuation of the Team to support proactive discharge planning for complex patients and admission avoidance. Working to the 'home is best' principle, supporting patients at home with appropriate enablement packages

(New projects for 15/16)

- **North Kent Urgent and Emergency Care Review**: To provide access to the highest quality urgency and emergency care within an integrated approach for the population of Swale
- **Partnership working with voluntary organisations**: To provide support to people within the community, reducing unplanned A&E attendances and admissions. Providing support to elderly patients on discharge from hospital
- **Falls prevention**: Working with social care partners, providers and MCCG to ensure a standard evidence based approach to identifying patients at risk of a fall and ensuring appropriate prevention services are in place

Programme Area: Urgent Care

Risks and mitigating actions:

- Large scale organisations change and patient behaviour change required to address impact of pressure from surges in non-elective activity. Significant focus and work in progress monitored through the Executive Programme Board
- Project Board Steering Group to oversee progress and delivery of North Kent Urgent and Emergency Care Review and Redesign
- Provider engagement in commissioning intentions will be key to their successful delivery which will be closely and regularly monitored
- Projects funded through 2014/14 resilience funds will be monitored and reported on a monthly basis to the Executive Programme Board through a PMO approach

Workforce implications:

- Implementation of the Integrated Primary care Teams and the expansion of the Integrated Discharge Team will be integral to the delivery of the reductions in post NEL attendances and admissions.
- Increased support from voluntary organisation s
- The commissioning intentions for urgent care aim to shift delivery of care, where possible, from the acute to the community. This may require flexibility by providers with their skill mix

Resource implications:

2015/16
Planned net savings: £863,584
Schemes within the Urgent Care Programme will contribute to savings in A&E attendances and short and long stay non elective admissions
Non elective long and short stay admissions: -£844,984
A&E Attendances: -£18,600

KPIs (linked to national KPIs):

- Achievement of all national indicators in relation to urgent care, including the 4hour A&E access target and ambulance response times
- Delivery of a reduction in non-elective admissions
- Delivery of a reduction in emergency admissions for acute conditions that should not usually require hospital admission
- Delivery of a reduction in the number of people admitted to hospital at the end of life and an increase in the number of people supported to die in their preferred place of care
- Increase in the number of people supported to live safely and independently within their home

Programme Area: Planned Care and Cancer

Objective:

- Improve access, quality, value for money and choice of services in appropriate settings and, where possible, closer to home
- Reduce Health Inequalities through tackling Cancer, Vascular and Respiratory disease

Key Drivers for Change:

- These pathways were identified in a number of GP forums as having a need for review, optimisation and simplification. Data shows an increase in demand for many of these services and a predicted rise in elderly patients is expected to increase demand.
- Cancer is one of three key causes or mortality for Swale
- In addition providers are reporting pressures on certain specialities (Dermatology, Ophthalmology, Neurology and Gastroenterology) due to either increasing demand or in some cases lack of capacity and availability of key specialists nationally. It is therefore imperative that we use our resources to commission the most efficient and effective service for the patients of Swale and make best use of the available expertise.

What did our providers and GPs tell us?

- There is complexity, duplication and workforce pressures in secondary care in dermatology and ophthalmology where there are community services that could be better integrated across the whole system. There are newly emerging pressures in Gastroenterology and Neurology impacting on service delivery.
- There is scope to introduce or improve provision of services in a primary or community setting to reduce pressure on secondary care and improve value for money e.g. Ophthalmology, Dermatology, ENT and Gynaecology, but this needs to avoid adding to the complexity and duplication.
- While there is a variation in the use of Choose and Book the general ethos of an electronic booking service that delivers efficiencies is welcomed by both GPs and Providers – therefore the delivery of a service that is easy to use is key
- Access to diagnostics is a continuing issue – whether GP direct access, timely introduction of new evidence based pathology (e.g. Faecal calprotectin),or within the hospital setting (e.g. on 2WW pathways).

What did our patients and local population tell us?

- Stakeholder/patient engagement events have told us that patients want, where possible, locally accessible services.
- They want complexity and duplication removed from the system therefore avoiding need for multiple appointments with multiple providers. They also want to ensure that services such as outpatient clinics provided in community setting are equitable with those provided in the acute hospital setting.
- They have also told us they would like to be involved in service redesign groups to give the patient voice.
- They have told us that they like Choose and Book when they have been offered the chance to use it.

Key projects and milestones:

- Integrated Community Dermatology – working with North and West Kent CCGs to procure a level 3 service providing a sustainable and value for money service offering appropriate and safe care in the right setting (procurement and mobilisation in 2015)
- Review of whole systems ophthalmology service – Working with North Kent CCGs procurement of new service in 2015 based on review findings. Continue in year pathway and workforce development building on PEARS and IOP Repeat Measures pilots.
- Medway Outpatient Improvement Programme – work on this has been wound back due to other priorities at MFT. Work has shifted to exploring options at other local Trusts for planned shift of OP work – evaluation of pilots in Cardiology, CoE and Respiratory at MTW.
- Cancer - Recruit and establish MacMillan GP Facilitator role to provide clinical leadership to Swale Cancer work.
- Cancer Improving access to early diagnostics – implementation of national directives for direct access to flexible sigmoidoscopy and brain MRI. Monitor impact.
- Cancer – having worked with Strategic Clinical Network to review pathways in Lung, Breast and Colorectal Cancer implement recommendations appropriately.
- Anti-coagulation care transfer – continuation of project to transfer care to community setting from the acute. Plan to procure a value for money service offering appropriate and safe care in the right setting (procurement in 2015)
- Continue review of ENT in particular community audiology and scoping of community ENT clinics.
- Scoping work to review Neurology and Gastroenterology services (2015)
- Pathology – review of pricing with MFT and scope of service including introduction of new and decommissioning of obsolete tests.
- Re-Procurement of AQPs in Independent Sector Electives and Diagnostics and Physiotherapy – subject to review.

Programme Area: Planned Care and Cancer

Risks and mitigating actions:

- Delivery of all commissioning intentions will be closely monitored on a monthly basis and mitigating actions identified to address any non-delivery.
- Any risks identified that may result in non-delivery are entered on the CCG corporate risk register which is reviewed on an on-going basis by the Governing Body.
- Transactional financial savings and best practice targets are dependant on contract negotiations and will need to be reviewed once negotiations finalised.

Workforce implications:

- Key within this programme is the acknowledgment that delivery of changes within this area is underpinned by ongoing education for clinicians – this will be provided via regular updates through CCG bulletins, website and Protected Learning Time events. We have successfully added a Practice Nurse education programme to PLTs through 2014 and will continue this. We have additionally organised a GP Hot Topics event in Cancer with SCN and will explore these opportunities further to develop our primary care workforce.
- In addition, key projects around ophthalmology and dermatology have been developed to address capacity issues within current services.

Resource implications:

2014/15:

- Planned net savings £375,464
- Transactional pathology pricing review -£300,000
- Transfer of activity to primary (including optometry) and community care setting (2404)
- DGH New outpatients reduction (-816)
- DGH Follow up outpatients reduction (-1255)
- DGH Outpatient procedures (-333)

KPIs (link to national KPIs)

NHS Outcomes Framework:

- Reducing premature mortality from the major causes of death – includes a number of cancer outcomes
- Delivery of NHS Constitution Access Targets – cancer waiting times and referral to treatment
- Improving outcomes from planned treatments
- Improving people's experience of outpatient care

Programme Area: Promoting Wellbeing and Mental Health

Objective:

- There is an ageing population and increased prevalence of chronic diseases that requires health services to move from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated.
- Over the next two years the CCG are focusing on developing mental health services within the community and primary care settings. The purpose of this being to increase identification and management of adult mental health conditions in primary care, including where this is secondary to a physical long term health condition. This is also to ensure patients get to the right mental health service, sooner and in a setting closer to home.

Key Drivers for Change:

It is reported that one in four people in England and Wales will have some form of mental illness over their lifetime
Mental Health accounts for nearly 40% of morbidity
The impact of mental health affects all sectors e.g. education, social, health, criminal justice system etc. increasing necessity for integrated services that are accessible and placed in a variety of settings.
Among people under 65, nearly half of all ill health is related to mental illness

What did our providers and GPs tell us?

Some of the areas highlighted as key to successful service delivery include:
Partnership working, Ensuring communication between clinicians
Patient owned recovery
Improved OOH access and awareness of OOH services available
Tools to support GPs in diagnosis and education/ training for GPs and practice staff
Timely access to specialist diagnostic opinion
Clear pathways

What did our patients and local population tell us?

Further development of dual diagnosis services in primary care (mental health/substance misuse)
Further strengthen links between health and social care – integration of services for older adults
The need for secondary care services to have a greater awareness and understanding of resources and services available in primary care and more services available locally
Development of early intervention services in primary care
More services specifically aimed at children and young people in primary care
Further work to raise awareness and reduce the stigma of mental health issues
Improve/raise standards and quality of primary care services

Key projects and milestones:

Key projects and milestones:
IAPT – Improving Access to Talking Therapies. In 2015-16 this service is continuing and will continue to contribute to expected outcomes.
Primary Care Mental Health Specialists – This service is continuing in 2015-16
Continuation of the Primary Care Community Link Worker project – jointly commissioned with Kent County Council
Neurodevelopmental Pathway – this project is located in the Integrated Commissioning programme summary. Service redeisgn encompasses transformation of ADHD & ASD services by procuring an all age care pathway to go live in 2016-17.
Personality Disorder Peer Support Group – this continues in 2015-16
New for 2015-16: - 18+ Community Mental Health and Wellbeing Service development in partnership with Kent County Council
New for 2015-16: - 0-25 Emotional and Wellbeing Service in partnership with Kent County Council
New for 2015-16: - Secondary mental health services continued transformation of urgent response services. The introduction of a Single Point of Access was implemented as Phase 1 in 2014-15.
New for 2015-16: - Review of all age Eating Disorders services against population need and demand to determine if current provision is appropriate for expected outcomes.
New for 2015-16: Liaison Psychiatry Service development - possible enhanced scope of service to focus on patient presenting with medically unexplained symptoms.
New for 2015-16: Perinatal Mental Health - review of current service provision within CCG commissioned services and Public Health services, reviewing needs assessment and current activity.
New for 2015-16: Street Triage service development in line with Crisis Care Concordat

Programme Area: Promoting Wellbeing and Mental Health

Risks and mitigating actions:

- Risk that required numbers of patients to be referred to Primary Care Mental Health Specialists will not be met. We are working with KMPT to ensure appropriate patients are discharged. Steering Group in place to monitor. Results from the pilot so far indicate that this is not a concern.
- Risk that Primary Care Mental Health Specialists capacity will not meet demand. Sharing resource across the CCGs will alleviate this whilst also ensuring numbers to be discharged are realistic based on capacity.
- Risk that identified population need to enter talking therapies will not be met. Continuous engagement with GPs, working with providers. Advertisement on live it well website. Activity monitored through the local contracting and performance groups.
- GP practices have limited capacity and therefore primary and community services will be put in place are able to manage demand and support GP practices without placing unnecessary pressure on practices.

Workforce implications:

- Early Intervention posts to be recruited, and workers for the Personality Disorder peer support group are currently being recruited.

Resource implications:

2014/15:

- Planned net savings £80,370
- A&E attendance reduction (-41)
- all other activity included in block contract

KPIs (including link to national KPIs):

- Increase adult access to talking therapies
- Enhance quality of life for people with long term conditions
- Proportion of people feeling supported to manage their condition
- Improving people's experience of integrated care

Programme Area: Integrated Commissioning - Dementia / LD

Objective:

- To transform the current service provision for people with dementia and develop a redesigned integrated pathway where dementia, depression and anxiety are treated under the long term condition model of care and a person's needs are treated holistically factoring in physical and mental health needs together.
- Deliver more care closer to home by increasing the availability of expertise for assessment, treatment and on-going support for people with dementia and common mental health problems in the community.
- Enhancing the mental health capacity within primary and community care should stimulate referrals for diagnosis and increase the overall diagnosis rate.
- Reduce non-elective admissions and excess bed days, focussing pathways for complex elderly/patients with LTCs
- Deliver improved quality and value within current services and investment to reduce the inequalities in accessing all health services and health outcomes, including premature death, experienced by people with Learning Disabilities.
- Implement and monitor Joint Strategic Winterbourne plan with KCC.

Key Drivers for Change:

- The current pathway of care for people with dementia is fragmented with a need for improved support in the early stage of dementia.
- Increasing number of people with dementia admitted to the Acute Hospitals that are not known to current services and these people historically have long lengths of stay and end up in premature long term care placements.
- Diagnosis rates are still below the national expectation to deliver a 67% diagnosis rate by 2015.
- There are excessive waiting times for people with autism

What did our providers and GPs tell us?

GPs want a clear and concise pathway for assessment and diagnosis that is achieved in a timely manner and mental health nurses within the community that can support people post diagnosis.

Providers are unable to meet the current influx for memory assessment due to the increase in referrals for assessment and are co-developing the revised pathway with GP Clinical Leads.

What did our patients and local population tell us?

They want a rapid diagnosis, good clear information and signposting and a range of support post diagnosis. Carers want support and respite to help them manage the burden of caring for someone with dementia.

- **Key projects and milestones:**
- A range of projects with focus on appropriate admissions management of patients and timely discharge to ensure the best possible outcomes are achieved through timely access to a range of community based health and social care services.
- Assessment and diagnosis pathway for dementia – enabling earlier diagnosis. Develop community based dementia assessment services by expanding the role of mental health nurses to establish a pro-active approach to clinics in primary care.
- Develop and enable clear pathways of care by using a long term conditions approach to support for people with dementia and their carers and expand the range of local post diagnostic support services.
- Expand the range of jointly commissioned Carers services to provide Carers Short Breaks, crisis intervention and support hospital discharge.
- Develop the capacity and capability of primary care staff including receptionists and health care assistants by establishing a foundation level dementia awareness training programme within each locality.
- Autism – Increase contracted activity to meet increased number of referrals and eliminate remainder of waiting list in 2015/16. This will be an interim solution pending agreement of the neuro-developmental pathway.
- Winterbourne – Fully implement and monitor effectiveness of new integrated care pathway with enhanced community support. Continue to discharge patients in line with their care and treatment reviews.
- Expand the range of community based LD services (Statutory and Private/Voluntary sector) to meet needs of individuals discharged from hospital and reduce numbers being admitted; and improving Quality of care for people with Learning Disabilities.
- Integrated Learning Disability Commissioning – Work with KCC and other Kent CCGs to develop a Kent wide integrated approach to commissioning learning disability services as recommended in the BUBB report using the governance arrangements for the Better Care plan.

Programme Area: Integrated Commissioning - Dementia / LD

Risks and mitigating actions:

- People with dementia will continue to enter the care system in crisis leading to inappropriate admissions, long lengths of stay and carer breakdown.
- Mitigating actions: Further develop the Integrated Primary Care Teams to identify people with dementia at high risk of admission or carer breakdown and provide active case management to support at home.
- Enhance post diagnostic support and direct referral pathways to voluntary sector organisations.
- Future modelling of local tariffs for MH PbR identifies that post diagnostic support does not carry a high tariff and it would be disadvantageous to contract with an alternative provider.
- On-going monitoring of activity for admissions to Acute Hospitals to identify other areas for dis-investment

Workforce implications:

- Historically high vacancy rates in key teams may impact on service delivery.

Resource implications:

2014/15:

- Net saving £791,073
- Total activity reductions -796 from MFT and KMPT

KPIs (link to national KPIs)

- Deliver a 67% diagnosis rate for dementia by 2015.
- Reducing time spent in hospital by people with long term conditions
- Reduction in emergency admissions for conditions that shouldn't normally require admission
- Helping older people to recover their independence after illness or injury
- The NHS Outcomes Framework also has an aim to ensure people with dementia received timely diagnosis and receive the best available treatment and care
- The recent NHS Call to Action, requests CCGs to transform pathways of care to achieve early diagnosis so that effective care planning can be put in place

Programme Area: Children and Young People

Objective:

- Promotion of personalisation and patient centred care
- Reduction in A&E attendances and NEL emergency admissions.
- Deliver care closer to home through a hospital at home approach
- Alignment with the CCG's wider transformation programme on urgent care for adults.
- Delivery of the Healthy child programme
- Reduce health inequalities and improve health outcomes of children and their families through promoting early identification and prevention models
- Implement the new statutory duties and powers within the Children & Families Act 2014
- Commission local services to enable children and young people to remain in their local communities

Key Drivers for Change:
The implementation of these commissioning intentions will contribute to:

- A new multi-agency whole system approach to meeting the assessed needs of children, young people and their families through stronger community based provision, delivered through new approaches to joint commissioning with Kent County Council and Schools and Colleges.
- Roll out person health budgets.
- Roll out of the new 0-25 Education Health and Care Plans for children and young people with Special Educational Needs.
- Need for increased understanding of the child's and family's needs.
- Need for effective transitions at all key life stages including transition to adult services.
- Reduce escalation of child's challenging behaviour, family breakdown, self-harm, suicide risk and the need for high cost out of county placements.
- Reduction in Tier 3 CAMHS usage.
- Care is offered as close to home as possible to enable children and young people to actively participate in educational and community based activities.
- Reduction in avoidable admissions for Lower Respiratory Tract infections and for asthma, diabetes and epilepsy for under 19's
- Promoting self-care and increased confidence amongst children and young people to manage their condition.

What did our providers and GPs tell us?
Successful delivery can be achieved through adopting:

- A common approach to integrated working across health, education and social care.
- A multi-agency to early intervention and prevention
- New mutli-agency approaches to workforce training and development to promote early identification, intervention and improved standards of care.
- New primary care led models of care to improve communication and joint working.

What did our patients and local population tell us?
Families tell us that they want to tell their story only once, have integrated services that are responsive to the child's needs, close to home and with caring staff who know the child and their needs.

CCG led patient and public engagement events confirmed that there was a desire amongst members of the public to have an increase in community based services nearer to where they live and fewer hospital based services.

Key projects and milestones:

- Swale and Medway Community Children's Nursing Service (CCNS) - Develop a new integrated community children's nursing service that offers care closer to home and promotes greater integration between primary care, community based services, local and tertiary acute providers. The service will support children aged 0-19 years with long term conditions, disabilities and complex continuing care conditions (including neonates) and children with life limiting and life threatening illness including palliative and end of life care. This service may also include children's therapy services.
- Challenging Behaviour – Enhance the specialist input provided at an earlier stage to prevent breakdown of the family support network for children with a learning disability, autism spectrum disorder and/or mental health condition and therefore prevent/reduce out of area placements. This enhancement will need to be aligned to the new, and developing, all age neurodevelopmental pathway.
- Neural Impairment and Physical Disabilities - Additional investment in OT and physiotherapy to support specific care pathways as part of an improved approach to supporting disabled children and young people with neural impairments and physical disabilities. This will enable the CCG and Local Authority to comply with new joint commissioning duties as detailed in the Children and Families Act 2014. It is possible that this function could be built into the model design of the Community Children's Service scope (i.e. to include therapies as well as nursing within the model).
- Acute Services - Audit of maternity services to ensure that expectant mothers are following, and are coded, on the correct Maternity Payment Pathway. A higher proportion of expectant mothers booking at MFT are recorded on the intermediate pathway than is reported across the region. Additionally, a full review of MFT community paediatric service will be undertaken in order to identify capacity and demand on different aspects of the service . This will identify the content of the block and tariff parts of the contract and will result in the development of up-to-date service specifications which will form part of the MFT contract.
- The development of a tender process, that procures a Kent and Medway wide service, which provides a standardised and consistent level of service to Looked After Children (LAC) irrespective of where the child is from in Kent or where in Kent they are placed.

Programme Area: Children and Young People

Risks and mitigating actions:

- Escalation of children being sent to expensive out of county placements, exclusion from schools, family breakdown, eventual placement in adult services.
- Gaps in service of therapies for children with PD. Inability for children to lead independent lives, free of pain, ability to take part in activities and increase in poor health outcomes.
- Children not able to communicate, affecting education attainment and social interactions.
- Possible escalation into social exclusion, poor behaviour, isolation, crime and inability to gain employment.
- Tribunal challenges and costs for CCG resulting from parental dissatisfaction at lack of service for child who has an Educational, Health and Care Plan (EHCP).
- Increase in children accessing acute services, year on year increase on A&E attendances
- Poor health outcomes for children and young people in care due to failure to provide quality and timely assessments of health needs
- Failure for CCG's to meet their Statutory Requirements for Children in Care and those CIC with an adoption plan.
- Less integrated working, information sharing, team around the child and family.
- Cost pressures for CCG due to increasing use of expensive specialist services
- Within the Mandate for the NHS and Everyone Counts it is a priority for NHS England to ensure that personal health budgets are offered as part of an Education Health and Care Plan. The Department of Health have asked CCGs to start the roll out of personal health budgets with children's continuing care and continuing healthcare packages from 1st April 2014.
- Lack of choice and flexibility for child and family when choosing care packages

Workforce implications:

- The successful delivery of the commissioning intentions will require the implementation of new mult-agency workforce training and development programmes to enable a broad range of professionals to ensure that children's needs are identified early and the right support is offered at the right time, in the right place.
- The commissioning intentions will require providers to review the skill mix of existing teams and how specific roles overlap across health, education and social care. This could also include looking at new enhanced roles to deliver specific outcomes e.g. the development of the Advanced Nurse Prescribers.

Resource implications: 2015/16:

2015/16:

* Planned net savings to be defined.
* Activity impacts included in block contract.

KPIs (link to national KPIs)

National Outcomes Framework:

- Enhance quality of life for people with long term conditions
- Proportion of people feeling supported to manage their condition
- Improving people's experience of integrated care
- 'No health without mental health'

Programme Area: Long Term Conditions including Health Inequalities

Objective:
Swale has the highest levels of deprivation in Kent apart from Thanet. The two highest causes of preventable deaths are CVD and COPD.
The aim of the Health Inequalities programme is to impact the number of deaths from CVD and COPD, reduce life expectancy variation and improve the quality of life for people in the Swale area.
We aim to do this by:

- Raising awareness of the causes of CVD & COPD via the continuation of the Beats and Breathes programme for 2015/16.
- Linking with and providing support for difficult to reach communities.
- Identify GP practice projects that focus on specific areas of Health inequality and support all practices to complete two projects per year.
- To forge closer working relationships and knowledge of the voluntary sector organisations, to help patients and carers to access the support that they need.

Key Drivers for Change:

There are significant health inequalities indicators for Swale including ill health from preventable diseases and significant difference of life expectancy between highest and lowest quintiles (10 years).

Swale CCG has addressing Health Inequalities as one of its key prioritiesThis is supported by the Health and Social Care Act and JSNA for Swale and Kent as well as the recently published '5 Year forward View' document. This sets out a vision of a radical upgrade in prevention and public health, to ensure that when people do need health services, patients will have greater control of their own care. It also highlights the need break down the barriers in how care is provided, e.g. between family doctors and hospitals; physical health and mental health and social and health care

Securing additional years of life for the people of England with treatable mental and physical health conditions.

Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.

What did our patients and local population tell us?

Public engagement events are always very well attended and very popular with local communities. The discussions with the general public has been positive and there have been changes in behaviours as a result of the engagement events

A comprehensive programme of engagement as part of the community services redesign project has identified that patients want to be supported to care for themselves, be able to tell their story once, and have seamless care across health and social care professionals.

Voluntary organisations want to strengthen relationships and knowledge with primary care in order that patients are given information they need to access local voluntary organisations, to help support them with their needs.

Key projects and milestones:

1. Continuation of Beats and Breathes Programme for 2015/16, building upon current feedback:
Practices' awareness and management of patients' disease in line with QOF indicators has shown improvement in delivery in most disease areas but there are still improvements that could be achieved by a systematic approach to individual practices' project work. This project brief content and processes for 2015/16 will be led by specialist nurses and will focus on three specific areas, Heart failure, COPD and AF stroke prevention. There will also be a Public Health indicator project to be completed by all that will systematically update public health status's (smoking, alcohol consumption risk and BMI) for registered patients. A clinical training session for clinical practice staff will be held to ensure the clinical implications of the selected project are understood.
Improved data intelligence will be supplied to GP practices in order for them to understand their local health inequalities status and individual CCG support will be tailored to meet the needs of that practice to help increase the identification of patients needing support for their condition. Non-elective admissions both long and short at MFT are showing a decrease trend.
The public engagement programme has seen approximately patients over 2014/15, providing advice and support with reference to support services for about patients and recommendations to see their GP provided for about patients. – have asked health trainers for 2014/15 data.

2. Review of the current programme, and development and implementation of extended health inequalities programme – Q4 2014/15 will be used for planning and training for implementation of Health Inequality projects from April 2015.

3. Implementation of the Better Care Fund programme, including:
Full Implementation of Integrated Discharge Team this will include Phase 2 roll-out of the Integrated Primary Care Teams, to expand them to include other key providers, including community pharmacy, to further support people with long term conditions both in terms of self-management and in the event of a crisis.
Implement an Integrated Dementia service within the community and rapid response teams
Develop an Integrated Primary Care Teams supporting GP practices, which deliver robust rapid response, geriatrician and physician services, long term condition management, mental health and social care support.
Patients enabled to access their health and social care record and enable key health and social care information to be made available electronically to relevant services

What did our providers and GPs tell us?

Practices that have participated have found patients on their registers that are not correctly identified within the appropriate disease areas. Knowledge gaps have been identified and training implemented.

In addition, GPs have identified the need for improved working with community nursing and social care to provide integrated support for people with long term conditions

Risks and mitigating actions:

Projects identified by practices either inappropriate or inadequate to identify those patients either missing from registers or at risk of getting key preventable diseases.

Public engagement activities only reaching the 'converted' with no follow through or ability to assess effectiveness – links being made with known hard to reach groups and activities being developed through established groups and communication links. Activities leaflet developed to support people – this can also be used to track activities and assess effectiveness of lifestyle changes.

New initiatives that are put in place, may not see health benefits for several years, therefore financial savings will not be realised in the short term.

The success of the comms and engagement work around health promotion messaging will be difficult to quantify.

Potential for an increase in prescribing due to more patients being identified as needing medication to help prevent more serious health conditions.

Workforce implications:

Programme managed by the Assistant Director of Partnerships and Health Inequalities with further support from a project manager. The programme is also supported by 2 part time band 6 specialist nurses and additional Health Trainer support for public events. There is a steering group in place with GP and specialist cardiovascular nurse membership.

Development of Integrated health and social care teams – work in progress with healthcare providers, and social care providers and commissioners to develop service specifications for each team, including identifying the impact on current and future workforce

Resource and activity implications 2015/16:

Planned net saving £147,865

Non elective admission (short and long stay) reduction – 63

KPIs (link to national KPIs):

KPIs for this programme area are predominantly related to reduction in A&E attendances or admissions which are articulated within the urgent care programme summaries:

100% of practices to increase their QOF disease registers numbers or provide evidence that the audit work has been undertaken and confirmed the low percentage achieved

100% of practices to ensure that 95%+ patients have been seen and annual assessment activities such as blood pressure and cholesterol have been undertaken

100% of practices to have reviewed their patients' medication and disease management regime in line with NICE guidance – evidence to be recorded as part of QOF

All practices to provide a QRisk assessment, providing lifestyle advice and information on support services as require for all patients on their Hypertension disease registers who are not on a CVD, diabetes or COPD register.

National targets:

Securing additional years of life for the people of England with treatable mental and physical health conditions – PYLL (Potential years lives lost) per 100,000

Health related quality of life for people with long-term conditions (measured using EQ5D tool in the GP Patient Survey).

Programme Area: Medicines Optimisation (GP Prescribing)

Objective:
The prescribing of medicines to patients is the most common for of medical intervention in the NHS and the GP prescribing budget is a significant proportion of the overall CCG budget – approx 14%. There are areas of prescribing within the CCG where the prescribing rates and costs are greater than the national average.
The aim of this programme is to reduce variation within the CCG, between practices and closer alignment to the national average in terms of prescribing trends.

Key Drivers for Change:
Within Swale, there is a 68.1% predicted increase in the population ages 65+ from 2011 to 2031 (i.e. from 22,600 to 38,000 people) and this increase is greater in the 85+ group, being predicted to increase 142.3% during the same period (from 2,600 to 6,300).
Older people and people with low socio-economic status have the greatest need to use health services and if the population continues to increase, there will be even greater pressure to prescribe leading to increased pressure on the prescribing budget.
The National Prescribing Centre (NPC) has updated it's document "Key therapeutic topics – *Medicines management options for local implementation*", which list topics in which there is variation in prescribing between CCG's and where there is room to improve prescribing quality and safety. Swale CCG is an outlier in several topics mentioned such as:

- Use of high dose inhaled corticosteroids in asthma
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Antibiotic prescribing – especially quinolones and cephalsporins
- First-choice antidepressant use in adults with depression of generalised anxiety disorder
- Hynotics

What did our providers and GPs tell us?
There are challenges faced by GP's within Swale due to higher than national deprivation levels. There needs to be better communication and working with secondary care colleagues.

What did our patients and local population tell us?
Any changes and alterations to patient's medication need to be communicated effectively and patients need to be supported during such changes.

Key projects and milestones:

- Implement primary care incentive scheme to deliver evidence based prescribing
- Implement new procedures and pathways for the prescribing of Oral Nutritional Supplements (ONS)
- Update and increase the use of the Dressings formulary and ordering process
- Review the need for an IT system for supporting GP's
- Develop community pharmacy services though the implementation of the Healthy Living Pharmacy (HLP) programme
- Implement shared care protocol regarding the provision of Melatonin for children
- Establish a sleep clinic joint with the community Paediatrician team at Medway Hospital

Programme Area: Medicines Optimisation (GP Prescribing)

Risks and mitigating actions:
Practices not engaged with incentive scheme – ensure effective consultation in development of the scheme and timely feedback during the scheme duration
Provider services not engaged to develop new pathways and formularies – Ensure effective project management and clinical leadership, from the Swale Medicines Optimisation Committee (MOC)

Workforce implications:
Identified the need for more capacity within the Medicines Optimisation Team. Extra Technician employed from the beginning of 2015.

Resource implications:

2014/15:
- Planned net savings £660,000

KPIs (link to national KPIs)

- 100% of practices engaged in the incentive scheme (19/20 practices engaged)
- Achieve net saving of £660,000 (November forecast – saving of £630,000)
- MCH dietician service to train/educate care homes/community staff on new ONS guidelines to help decrease spend by 10% - spend has increased by 25% (November data).
- GP/KCHT (community nursing) adherence to dressing formulary to reach a target of 75% (from 50%) – 60% achieved by November.
- Develop and implement Shared Care protocol for licensed Melatonin. Target of 75% prescribing of licensed melatonin (from 5%) – 51% licensed use by November.
- Work with KCC public health to implement the HLP programme in Swale. Target of 10 HLP - 13 pharmacies engaged and staff undergoing training, to be completed by Feb 2015.
- Review appropriate IT support systems for GP use – trial of system to begin in March 2015.

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NHS
West Kent
Clinical Commissioning Group

2015-16 Operating Plan Executive Summary (Draft)

24th February 2015

Patient focused,
providing quality,
improving outcomes

Executive Summary

Overview

In summer 2014 West Kent CCG set out its five year plan to improve the health and well-being of its population in its detailed Strategic Commissioning Plan. This paper provides a summary explanation of how our local strategy will continue to be delivered throughout 2015-16 and what we specifically aim to address in the next 12 months, year 2 of our Plan.

Intentions

Our **Top focus areas** for improving patient outcomes and quality of care for the people of West Kent in 2015-16 are:

- Earlier diagnosis of cancer – we will reduce the number of patients presenting at stage 3 or 4 and increase identification rates of patients at stage 1 and 2;
- Better outcomes for stroke – we will review and respond to our performance against the 8 key indicators;
- We will improve the early diagnosis of diabetes and uncontrolled blood sugars – we will prioritise the delivery of diabetes care in Primary Care;
- We will improve the management of patients with atrial fibrillation by ensuring appropriate interventions such as anticoagulation supported by Grasp AF. This will be a non-optional scheme within the GP LIS;
- We will review the impact of our respiratory pathway to ensure increased early identification and management in Primary Care of respiratory exacerbations;
- We will improve quality and reduce patient harm by seeking to reduce admissions from care homes, avoiding unnecessary movement of elderly patients and providing enhanced end of life care;
- We will transform children's emotional and well-being services and improve transition between services by delivering a system that meets needs from birth to 25 responding to the individual needs of a young person (CAMHS);
- We will increase uptake and completion of cardiac rehab, pulmonary rehab and diabetes education services to improve the quality of life for those living with long-term conditions and to reduce unnecessary hospital admissions and aid recovery from acute illness;
- We will improve existing continence services by initiating work to address gaps in specialised nursing services here and for Parkinson's and epilepsy patients;
- We will improve our dementia diagnosis rate and earlier detection. We will deliver better quality of care for people with dementia through an integrated pathway and proactive identification of carers;
- We will review and increase the provision of NICE approved psychological therapies (IAPT services) to support people with mental health problems manage their illness and improve access and uptake.

We will continue working with Public Health England, children's commissioners in the CSU and KCC on self-care, health inequalities and prevention agendas. In addition, the CCG expects to achieve

significant progress in 2015-16 on the process of alignment of health and social care provision, and the development of integrated local teams. To support delivery of the **Top focus areas** for West Kent we will be addressing:

Development of Primary Care

- Through microsystems support and the premises challenge fund, a directed LIS to drive improved outcomes and the Primary Care business support hub
- We will implement a new GP LIS focused on improving outcomes for patients in West Kent. Practices will be asked to review every cancer diagnosis from last year for learning points and improve outcomes for Atrial Fibrillation patients as mandatory elements of the LIS.

Infrastructure requirements

- With the application of new technology in the form of the Care Plan Management System (CPMS), electronic referrals and discharge summaries and electronic conferrals to reduce non-elective activity and drive a percentage reduction in outpatient referrals

Access

- By providing more of the patient pathway outside of an acute hospital setting, ensuring choice and our access commitments are being met
- And supporting the achievement of the A&E 4 hour waits target, improved Category A ambulance response times and better use of out of hospital facilities;

Parity of Esteem

- With the implementation of the requirements of the mental health crisis care concordat and the mental health code of practice
- And the development of existing services – i.e. CAMHS, IAPT, Dementia and Crisis Care – to meet the 'parity of esteem' agenda;

Procurements

- With procurements in Dermatology, Out of Hours and ERRs, AQP Electives and Diagnostics, and equipment stores;

New Requirements

- By achieving targeted performance for IAPT access at 6 weeks and 18 weeks, improved Dementia Diagnosis rates and 80% electronic referrals and discharge summaries

Current Position

Areas for Improvement

We have seen performance worsen against key NHS domain outcomes such as potential years of life lost (PYLL) and under-75 mortality for cancer, liver disease and respiratory disease in West Kent over the past 5 years, which is why it is so important that the **Top focus areas** are successfully delivered.

Our Dementia diagnosis rate must increase from 52% to at least 67% by the end of October.

Performance for our patients against NHS Constitution targets this year has been varied. It has been above target against Cancer waits, 18 weeks Referral to treatment (RTT) and 6 week diagnostic test waiting times but below target for 4 hour waits at A&E and response times for Category A ambulance calls, which is unacceptable for West Kent, and we have recovery plans in place to address this.

Against the NHS Outcomes framework, West Kent CCG has reduced the incidence of unplanned or unnecessary hospital admissions but has not seen improvements to acceptable levels in PROMS

outcomes and falls in patient experience of GP services. We have significant Primary Care Variation in referral and prescribing practice which has implications for both patient outcomes and our long-term financial stability.

Locally, cardiac rehab completion rates have exceeded target levels and this must continue, as must our improved take up of IAPT services with those entering treatment.

Quantified delivery priorities and objectives

West Kent CCG aims to meet, and where possible surpass, all national targets across the NHS Constitution, NHS Outcomes Indicator framework, Other Commitments and Primary Care:

Delivery Priorities	**WKCCG Commitment**
RTT - Admitted - E.B.1	90%
RTT - Non - Admitted - E.B.2	95%
RTT - Incomplete - E.B.3	92%
Diagnostics (minimum achievement) - E.B.4	99%
Cancer Waiting Times - 2 week wait - E.B.6	93%
Cancer Waiting Times - 2 week (breast symptoms) - E.B.7	93%
Cancer Waiting Times - 31 Day First Treatment - E.B.8	96%
Cancer Waiting Times - 31 Day Surgery - E.B.9	94%
Cancer Waiting Times = 31 Day Drugs - E.B.10	98%
Cancer Waiting Times - 31 Day Radiotherapy - E.B.11	94%
Cancer Waiting Times - 62 Day GP Referral - E.B.12	85%
Cancer Waiting Times - 62 Day Upgrade - E.B.14	85%
Cancer Waiting Times - 62 Day Screening - E.B.13	90%
Ambulance Performance – Cat A 8 mins Red 1 E.B.15.i	75%
Ambulance Performance – Cat A 8 mins Red 2 E.B.15.ii	75%
Ambulance Performance – Cat A 19 mins Red 1 E.B.16	95%
A&E Performance – 4 hour waits	95%
C. Difficile - E.A.S.5	97 (case ceiling)
Dementia - E.A.S.1	66.70%
IAPT Access – Entering treatment (annual) - E.A.3	15%
IAPT Recovery - E.A.S.2	50%
Mental Health Access - 18 Weeks - E.H.2 - A2	95%
Mental Health Access - 6 Weeks - E.H.1 - A1	75%
Satisfaction at a GP Practice - E.D.1	439/500
Satisfaction at a Surgery - E.D.2	85.8%
Satisfaction with access to primary care - E.D.3	74.7%

Continuation of our existing commissioning intentions

Our plan this year addresses new requirements and aims to correct any under-performance identified to date. However, it also sees the continuation of work begun last year in a range of areas. The specific outcomes for these over the next 12 months include:

- The creation and development of integrated pathways across a range of specialities with the aim of transferring care out of the acute setting. This is applicable for ophthalmology, dermatology, diabetes, respiratory services and cardiac rehabilitation;
- The ramp up of transformation of outpatients to be expanded to cover a wider range of specialties and a larger number of GP practices;
- A review of how the acute trust is incentivised to reduce the number of follow-up appointments by developing pathways that offer greater value for money for the system and better quality for patients;

- The development of strategies and specifications for orthotics, self-care, tele-health and care homes.
- The development of an integrated ERRS and New Primary Care units at both A&E's and OOH services specification for procurement and commissioning during 2015;
- Development of short stay emergency activity tariff and review of the way in which the treatment of the ambulatory conditions set can be restricted in the acute setting;
- A review of frail and elderly care, the means of minimising delayed transfers of care, falls, community hospital bed usage and reporting times for routine diagnostics;

We have paused for evaluation:

Expert Patient Programme; Roving GP.

These were piloted but are not continuing because they did not evidence the patient outcomes, quality impact or return on investment we'd sought. The original High Intensity Therapy (HIT) Team was stopped and subsequently revised, as was the Take Home and Settle service.

Winter resilience funding

This year we invested in (amongst other things) escalation beds, commercial beds, the revised HIT Team in A&E, the Romney ward, and funded 7 day working.

For 2015-16 we will need to review this as we will not be able to continue everything; there has been a lack of reduction in non-elective admissions plus we have received reduced funding this year. We avoided long-term commitments in anticipation of this but will need to make tough decisions going forward.

Recovery plans

These have been developed where performance is not in line with the CCG Outcomes Indicator Set target for A&E 4 hour waits (E.B.5), IAPT entering treatment (E.A.3) and Dementia diagnosis rate (E.A.S.1). Their status is regularly reported to NHS England and will continue to be until performance has reached and stabilised at target levels.

Whole-system view

WKCCG's 2015-16 Commissioning Intentions are influenced by the Five Year Forward View, our 'Mapping the Future' goals, the joint Health and Wellbeing Board (H&WB) Priorities, our Provider's plans, ongoing patient and public engagement process, consultations with providers and key stakeholders and further work undertaken locally in Programme Oversight Groups (POGs) and at Clinical Strategy Group (CSG). In addition, services that were seen to be not delivering quality, outcomes or value for money have been prioritised for improvement.

Assurance that the CCG has a robust demand and capacity model aligned with providers

Ref to key Provider Plans – i.e. MTW, KMPT, KCHT, SECAmb

Five Year Forward View & Commissioning for Value

- Our planning has been validated against the triple aims of Quality, Patient Outcomes and Value. This is to ensure the operating plan continues to address the key areas where we are an outlier in service outcomes and quality; that our focus has a justifiable evidence base; that we can prove the plan offers the best value for money for the local population.
- The Operating Plan also responds to the Commissioning for Value pack advising where we have outlier status against peers, for example in Diabetes, Trauma, Stroke and Cancer.

Joint Health & Wellbeing Strategy

- Published by the Kent Health and Wellbeing Board and authored by commissioners, patient representatives and elected officials, the Joint Health and Wellbeing Strategy lays out a clear vision for Kent. The Operating Plan therefore takes into account the 5 key outcomes identified and the 4 Priorities assigned to each Outcome, which align strongly to the Five Year Forward View.

Better Care Fund

- The growth in NEL admissions over winter 2014/15 has shown that achieving our original ambitions of a 3.5% reduction would be extremely challenging for the whole Kent-wide health system to deliver. As such, discussions have taken place at the Kent Health and Well-Being Board about moving to a more appropriate and achievable NEL reduction target across Kent. Discussions have also been ongoing between the CCGs across Kent, NHS providers and social care partners. The Kent Health and Well-Being Board has accepted a 0.8% reduction in NEL admissions as a more realistic target. Therefore, going forward West Kent is reducing its level of ambition in NEL admissions from 3.5% to 0.8%

Assurance process

The same process to ensure internal assurance in the development of this operational plan refresh has been employed as for the generation of the main operating plan in 2014, specifically: oversight from Chief Operating Officer, Lead Clinical GP Commissioner input at Clinical Strategy Group (CSG) meetings, guidance and input from Governing Body (February meeting), finalisation of content at Governing Body (March meeting).

Next Steps

Internal and external agreement of programmes / plans, including H&WB board, further Public and Patient engagement (PPE), and against Five Year Forward View (FYFV) / Commissioning for Value (CfV)approach. Pursuit of outstanding assurances and delivery of recovery plans.

Agreement of Better Care Fund (BCF) programme outcomes and costs with Kent County Council. Finalise contract round with key providers. Address issues fed back from the AT. Development of final detailed operational project plans for approval at Clinical Strategy Group (CSG). Launch of 2015-16 programme delivery phase start of April.

NHS England

NHS England (Kent and Medway)

Direct Commissioning Strategy and Two Year Operational Plan

2014 to 2016

THE NHS CONSTITUTION
the NHS belongs to us all

CONTENTS

SECTION 1: INTRODUCTION

1. This paper provides information about NHS England (Kent and Medway)'s commissioning plans for 2014/15 and 2014/15.
2. NHS England (known legally as the NHS Commissioning Board) is an independent organisation that operates across England, at arms-length from government. Through its twenty-seven local area teams, NHS England is responsible for directly commissioning:
    - primary care services (GP, dental, optometry and pharmacy services);
    - secondary care dental services;
    - specialised healthcare services;
    - healthcare services for offenders and those within the justice system;
    - a range of public health service on behalf of Public Health England (e.g. covering pregnancy to age five public health programmes, screening and immunisation programmes, sexual assault referral centres); and
    - some healthcare services for the armed forces.
3. NHS England (Kent and Medway) is the local arm of NHS England (also known as the Kent and Medway Area Team).
4. In regards to its direct commissioning functions, NHS England's focus is on improving health outcomes for patients and ensuring equity and consistency in the provision of health services, but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally.
5. NHS England also works closely with local clinical commissioning groups (CCGs) to support them to use their local knowledge and understanding of the needs of local patients to commission a wide range of other community and hospital services.
6. Work is taking place to develop five year commissioning plans. It is important that this two year plan, which needs to be submitted to an earlier timescale is also presented within the context of, and fits within, the overarching strategic direction of travel. Therefore, this document contains information on the strategic direction for the services directly commissioned by NHS England (Kent and Medway) and this document should also be read in conjunction with NHS England (Kent and Medway)'s Strategic Framework for Primary Care.

The national context

7. Each year the Government publishes the NHS mandate setting out ambitions for the National Health Service. This can be viewed at https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015. The mandate details the outcomes that the Government wants the NHS to achieve for patients but gives clinical commissioning groups (CCGs) and NHS England (through its direct commissioning role) flexibility on how these are delivered.

8. Much of the basis for the Government's mandate originates in the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see within the health service:

   a. We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.

   b. We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.

   c. We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.

   d. We want to ensure patients have a **great experience** of all their care.

   e. We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

9. Delivering these identified long-term ambitions will require transformational change across health and care systems and in the way health services are delivered. That is why in July 2013 NHS England (along with our national partners) launched *A Call to Action* which set out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. We need to find ways to raise the quality of care for all in our communities to the best international standards, while closing a potential funding gap of around £30 billion by 2020/21.

10. On the 20th December NHS England issued planning guidance to CCGs and NHS England direct commissioners titled Everyone Counts: Planning for Patients 2014/15 to 2018/19. This sets out how it is proposed to invest the NHS budget so as to drive continuous improvement and to ***make high quality care for all, now and for future generations*** into a reality. The planning guidance can be viewed at http://www.england.nhs.uk/2013/12/20/planning-guidance/ and will be used to inform the development of local health services in Kent and Medway.

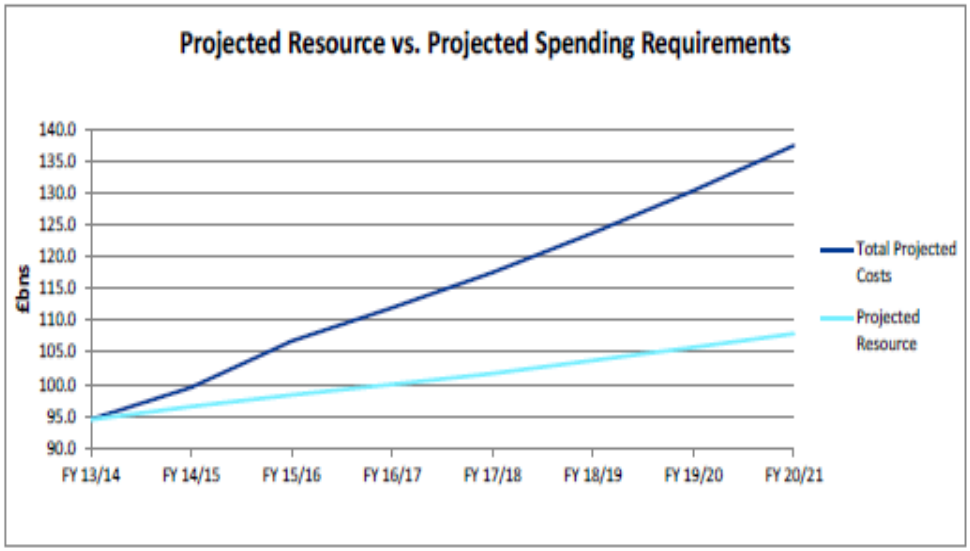
11. Change will need to be achieved through:

    - Listening to patient views
    - Delivering better care by realising the benefits of the digital revolution
    - Transparency and sharing data about local health services
    - Transforming primary care services
    - Ensuring tailored care for vulnerable and older people
    - Delivering care in a way that is integrated around the individual patient
    - Ensuring access to the highest quality urgent and emergency care
    - A step change in the quality of elective care
    - Providing specialised services concentrated in centres of excellence
    - Improving access to services (e.g. moving to seven day service provision)
    - Supporting research and innovation
    - Developing an integrated training model

12. NHS England is focused on ensuring equity and consistency of provision but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally. The following sections provide information on the development of commissioning plans and intentions for those services that NHS England directly commissions for the population of Kent and Medway, taking account of the national planning guidance and commissioning intentions.

The financial challenge

13. Nationally there is a forecast national financial gap of circa £30 billion by 2020/21. This is shown on the graph below. This details projections around the raising costs of NHS healthcare, largely due to an aging population (described later in this document) and projected resources (i.e. funding) that will be available to meet this demand.



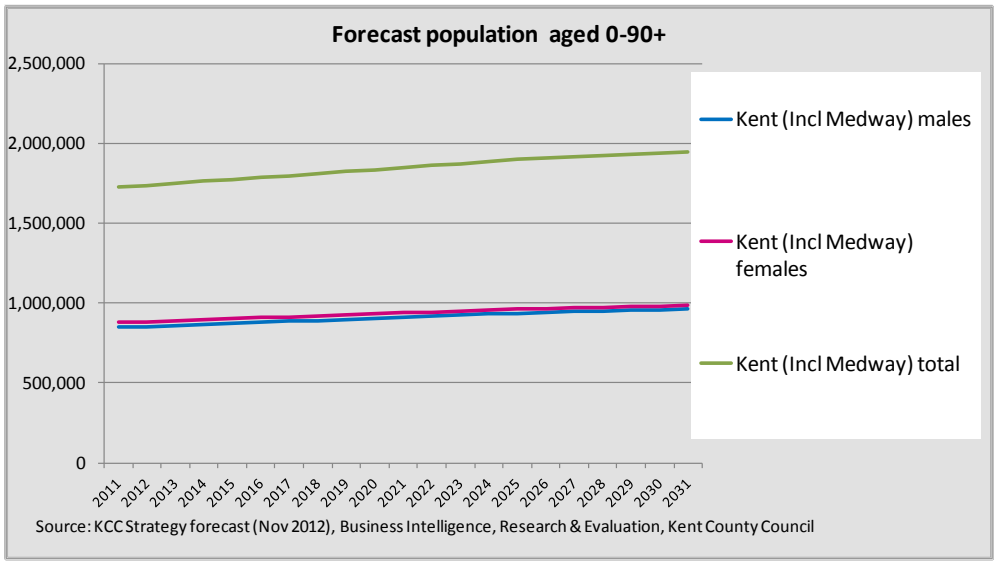
14. As a crude approximation the Kent and Medway weighted population is 3.14% of the national population, so our financial challenge is circa £1 billion of the £30 billion call to action challenge across all NHS commissioners.

15. The affordability challenges (or more accurately the demand challenges) in 2014/15 and 2015/16 are real and urgent. The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases, presents a significant challenge to the way we currently commission and provide care.

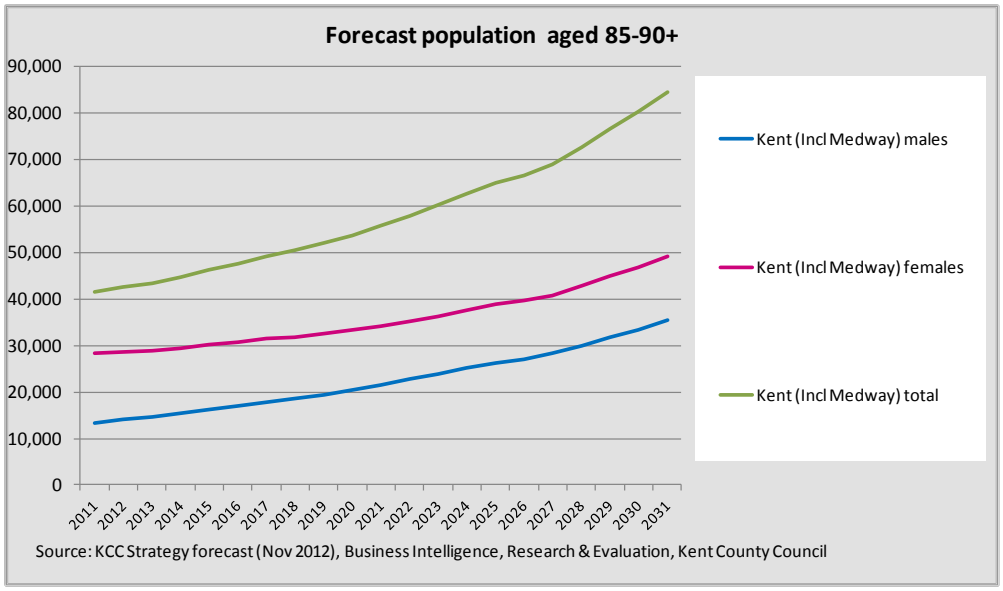
SECTION 2: THE KENT AND MEDWAY POPULATION

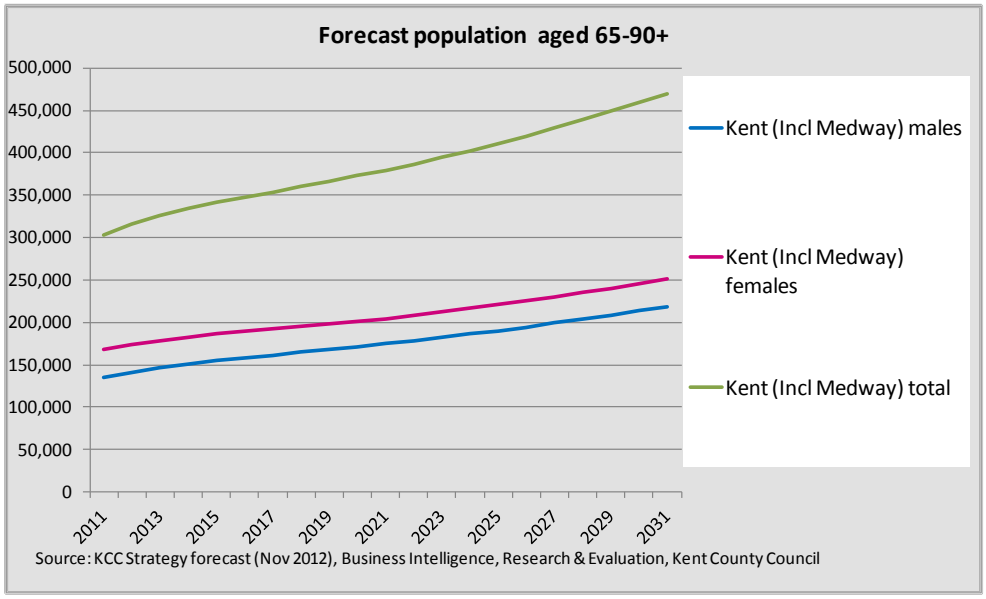
A changing population

16. By 2021 it is projected there will be a 5.4% increase in the total Kent and Medway population, which is shown on the following graph:



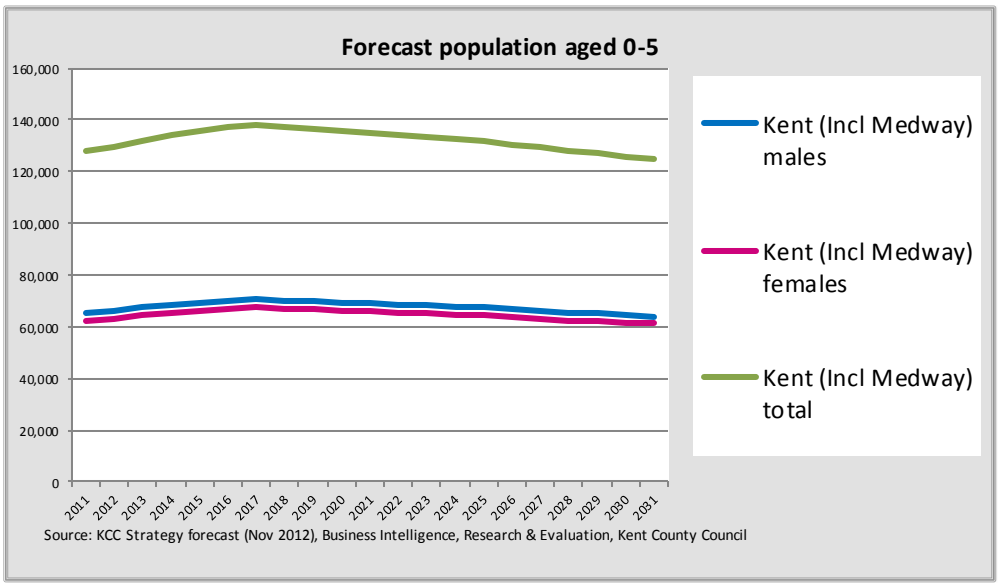
17. Whilst this increase in total population in itself is significant, it masks a more significant issue in that it is projected that over the same time period there will be a 25.5% increase in number of people aged over 65 years and a 34.1% increase in number of people aged over 85 years. This is shown on the following graphs:





18. In practice this means the percentage of older people in the total population is increasing; this is often referred to as "an aging population". This presents two challenges in that older people generally require more health and social care support, plus the percentage of the population who are of working age and paying taxes diminishes (i.e. there is less income from taxes to fund public services). It is this situation that is driving the financial challenge that was outlined earlier in this plan.

19. The area team, through its public health commissioning functions, also has specific responsibilities for children aged 0 to 5 years old. The change in this population is shown on the next graph. Whilst there is a short term increase projected in the number of 0 to 5 year olds, this growth is expected to plateau in the next 3 to 4 years (although further modelling is needed to assess the impact of immigration), after which this population will start to decrease.

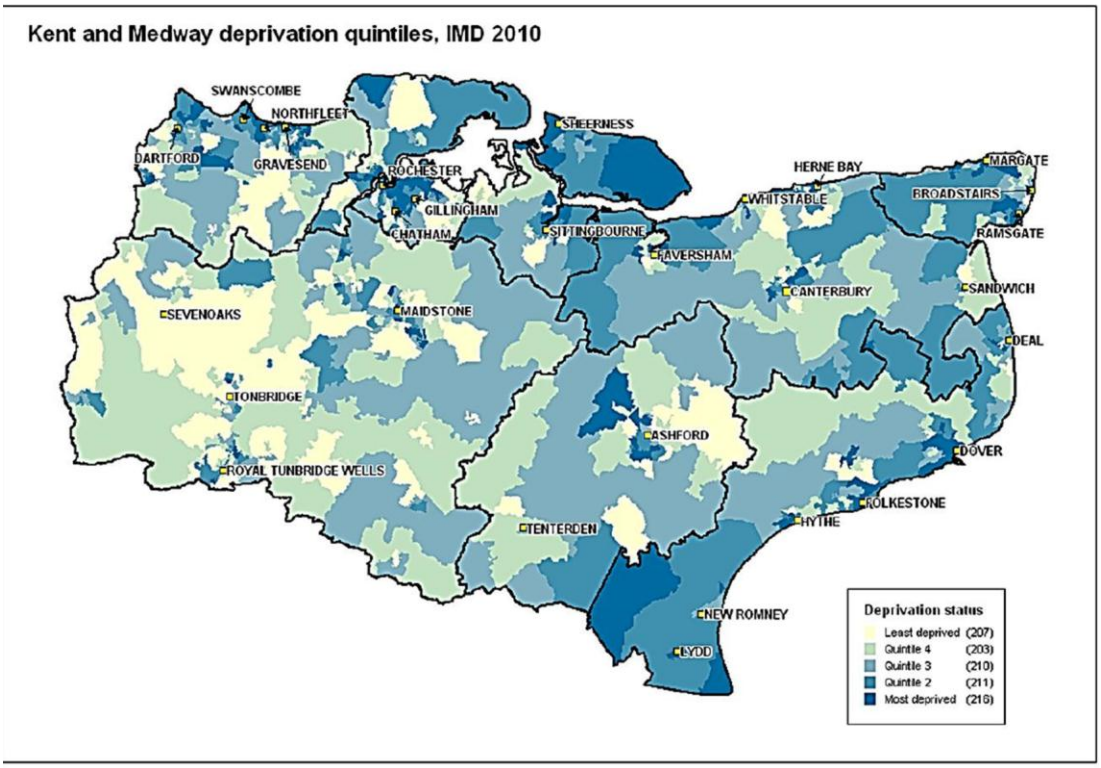


Inequalities

20. Health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness are among those more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population.

21. Health inequalities start early in life and persist not only into old age but subsequent generations. Tackling health inequalities is a top governmental and local priority for NSH England, as well as for our partners. Tackling health inequalities is focused on narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall.

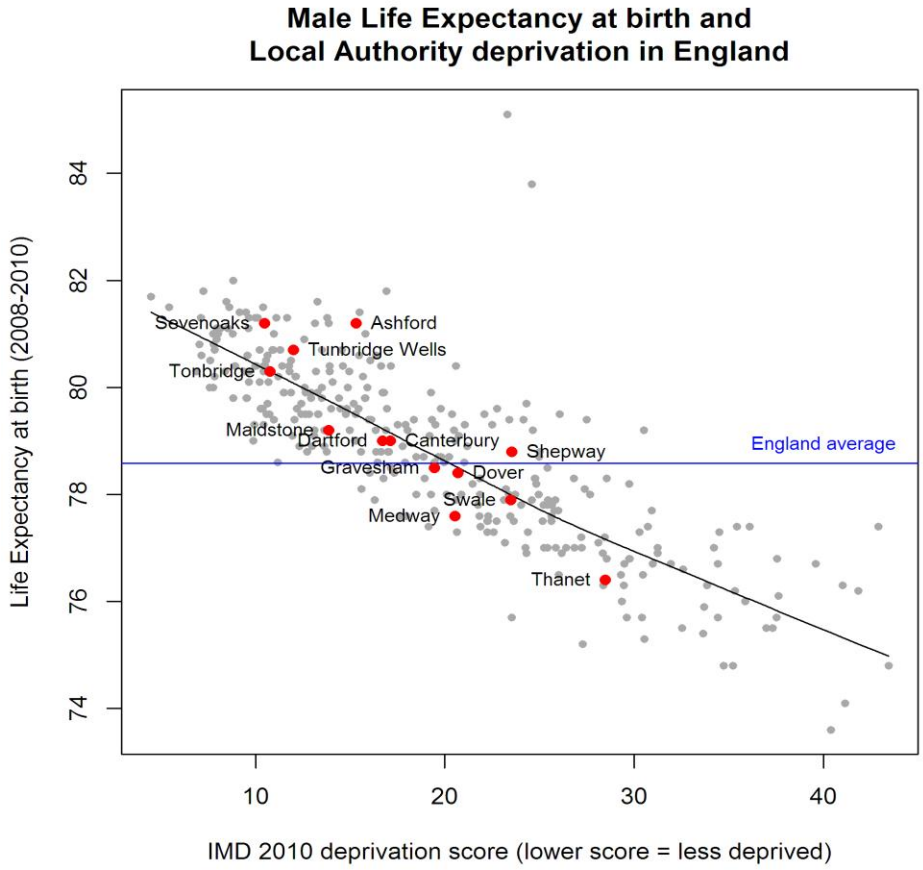
22. Within Kent and Medway there are significant health inequalities. The following map gives an overview of deprivation across the area. The darkest areas are the most deprived.



23. Whilst many areas of Kent and Medway are affluent, with higher levels of "wellbeing" (this includes indicators on life satisfaction, how worthwhile life is considered to be, happiness and anxiety) there are also a significant number of areas in the most deprived quartile of the population This is illustrated in the following table which shows life expectancy and the "slope of index inequalities" (a measure of deprivation) by CCG.

Clinical Commissioning Group	Average Life Expectancy	Slope index of Inequalities (SII) (is calculated by taking into consideration Indices of Multiple Deprivation (IMD) and Life Expectancy at birth and is an indicator of the gap between the most and least deprived).
Ashford CCG	82.6	3.0
Canterbury And Coastal CCG	81.6	4.6
Dartford, Gravesham and Swanley CCG	80.9	5.8
Medway CCG	80.3	4.9
South Kent Coast CCG	80.7	5.0
Swale CCG	79.8	5.5
Thanet CCG	79.4	7.1
West Kent CCG	82.3	4.2
Kent and Medway	81.1	5.6

24. This variation in health inequalities is further illustrated by the following chart that shows a correlation between deprivation and male life expectancy (i.e. this shows the link between deprivation and reduced life expectancy).



25. Whilst the information above shows a difference of about 5 years in life expectancy between the least and most deprived areas (e.g. between Thanet and Sevenoaks), this data is presented at CCG or district council level and hides

the greater disparity between the least and most deprived wards. More information on this is in CCG and local authority plans (including the Annual Public Health Report and the Joint Strategic Needs Assessment).

SECTION 3: MAINTAINING A FOCUS ON QUALITY

26. Knowing that patients are safe in our care is of paramount importance and one of the main categories from the NHS Outcomes Framework relates to keeping patients safe and protecting them from avoidable harm.

27. Everyone Counts describes the key components of quality (effectiveness, patient experience and safety). This focuses on the fundamental principles of the:

    - Francis report and the need to improve high quality, safe care.
    - Berwick report and the need to foster a safety culture
    - Winterbourne report describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.
    - Transforming Care: A national response to the Winterbourne review describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.
    - Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework: Promote partnership working to safeguard children young people and adults at risk of abuse at all levels. Ensuring professional leadership and expertise including the responsibility of named professionals for safeguarding children and adults, recognising that safeguarding is everybody's business. Lead with partner agencies to implement national policies to prevent child sexual exploitation, female genital mutilation, sexual violence and domestic abuse.
    - Clwyd-Hart report on NHS complaints

28. In response to the need to continuously improve patient safety and reduction of avoidable harm we will continue to:

    - develop the Quality Surveillance Group oversight across Kent and Medway;
    - implement the new patient safety alerting system;
    - drive to reduce the incidences of Healthcare Associated Infection (HCAI);
    - implement of the new Patient Safety Collaborative Programme;
    - implement the new patient safety thermometers;
    - promptly action Care Quality Commission notices and enforcement notices;
    - learn from Serious Incidents and Death in Custody reviews; and
    - innovate and utilise national models to support safe staffing delivery

29. Intelligent, collaborative commissioning will be undertaken with partners, including regulators of health care services. Within Kent and Medway we will manage a quality work programme for Health and Justice and Primary Care. Through this we will promote a positive experience of care, ensuring the patient's voice is heard, listened to and acted upon. This includes timely responses to and learning from complaints.

30. Wherever possible we will support people in maintaining their own health and thus not requiring healthcare services but where necessary. We want to ensure that every patient has a positive experience of health care and we will continue to:

- be proactive in response to complaints;
- ensure the patients voice in heard, listened to and responded to;
- improve the experience of carers;
- support Friends and Family Test (FFT);
- develop the concept of no decision about me without me and implement patient centred approach;
- implement the Compassion in Practice and methodology of the six Cs;
- safeguard those patients who are the most vulnerable working collaboratively with multi-agency partners;
- enhance the ability of patients and the public to care for their own health;
- ensure full respect for patient autonomy in decision making and ensure patients can access advanced care planning options; and
- ensure our systems are simple and straightforward to access and that appropriate choices and option are clearly signposted.

31. The quality and nursing team are concentrating on three areas of work for the next two years:

- Quality governance
- Health improvement
- Safe workforce

Quality Governance

32. Many of the organisations that we directly commission can be placed into one of four levels of development in quality governance:

Level zero	The Organisation is working in isolation, tends not to engage in local programmes or Area activities. They do not have any quality governance meetings and only report incidents if requested by commissioners.
Level one	**Foundation level** Multiple and disparate action plans in place, basic clinical governance meetings held intermittently with poor attendance and no clear outcomes. The organisation reports only Serious Incidents when a death in custody occurs or a death on the premises in primary care. No reports into clinical governance for incidents and no risk register is presented. No identification of changes to practice as a result of root cause analysis investigations.

Level two	**Intermediate Level** Strategic action plan starting to be developed and quality governance meeting reviewed and in place attended by all partners delivering care. Risks are starting to be identified and a process for mitigation is in place. The organisation is starting to show an open and transparent reporting culture. The organisation engages with area and local events and networks.
Level three	**Mature Organisation** The quality governance meeting is well organised, attended by all partners, receives regular appropriate reports and proactively monitors the review and implementation of the strategic action plan. Clear safety reporting structure is in place and reporting is encouraged by the organisation. There is a clear open safety culture with the organisation proactively assessing the culture at least annually. The organisation routinely examines and where necessary implements changes to policy and practice as a result of incidents reported, complaints or from staff and patient survey analysis. Dynamic process of identifying, reviewing and mitigation identified risks. They are a system leader for improvement programmes.

33. The aim is to have all directly commissioned organisations to be at level 2 by March 2015 and 75% of organisations starting to or achieving level three by the end March 2016.

Health improvement programmes

34. Existing data collection methodologies (e.g. friends and family test, safety thermometer, healthcare acquired infection returns) will be used to establish dynamic health improvement programmes initially focused on pressure ulcers, healthcare acquired infection. A serious incident learning network will also be established by July 2014 led by a CCG and or a local provider by July 2014. In addition:
    - by March 2015 there will also be improvement programmes for venous thromboembolism, medication errors and sepsis; and
    - by March 2016 there will be an improvement programme for the emerging safety thermometer work streams of mental health and maternity harms.
35. The aim is these will all have the overall impact of achieving zero avoidable harm in patient care. This work is also a precursor to the Patient Safety collaborative being established.

Safe Workforce

36. Francis and Berwick both highlighted the importance of a well- trained and well-staffed establishment to ensure safe patient care. We will work with our partners in health education England Kent Surrey Sussex, to ensure there are sufficient learning opportunities for staff in our directly commissioned services.

37. We will also ensure that safe staffing is reviewed within the service specification and commissioning process and will seek opportunities to work nationally in the assessment and review of such staffing levels.

38. The Kent and Medway area team will pursue a longer term strategy for work force development and work with national professional organisations to commission specialist education in order to raise standards and quality of care.

39. Throughout the work of the Nursing and Quality team we will work under the principle of collaboration with our own internal partners within NHS England, CCGs and local providers to ensure stronger engagement for quality throughout the commissioning cycle.

Quality in primary care

40. We intend to support clinicians to provide optimum care for patients by facilitating the development of a strong governance culture throughout the area. This will include more integration to prevent clinical isolation and the development of stronger processes to identify variation in performance and offer early support and intervention. We have taken learning in this area from our work in clinical governance and from incidents that have occurred in primary care. To improve the quality of primary care and to keep patients as safe as possible from avoidable harm, our areas of focus are to:

- improve the way that safeguarding training is implemented to ensure that all clinicians who need training have been trained. In addition, to improve the way the safeguarding training is embedded in practice so that people really understand what it means and how and when to raise a concern;
- improve the complaints systems for primary care. We need to ensure that verbal complaints (not just written ones) are recorded, considered and acted upon, and reported to identify trends that need to be addressed;
- improve the way in which informed consent is given by patients for procedures performed in primary care;
- empower all clinical staff to challenge inappropriate or questionable behaviour;
- embed better two way communication about concerns with Care Quality Commission;
- ensure that GPs with Special Interests (GPwSI) are appropriately monitored for the work that they do; and
- improve practice manager's skills and core competencies.

41. In order to mitigate risks the Medical Directorate actively leads the Quality Hub and ensures appropriate links are made both internally and externally. Complaints are also actively monitored and reviewed to see if there are any performance concerns.

42. In relation to raising the quality of primary care in general, we are aware that Kent and Medway struggles to attract the best applicants to work in the area. There are many reasons for this, one key problem is the lack of a University with a Medical and Dental school as quality applicants tend to live post-qualification in the area in which they trained. Poor quality applicants are more likely to be of concern later on in their careers. NHS England (Kent and Medway) is looking to work with Health Education England, CCGs and the local Medical Committee to develop a primary care workforce plan for general practice. We are also working with CCGs, including utilising the Better Care Fund (BCF), to look at skill mix, using a range of skills in primary care, and a health and social care workforce plan.

43. Professional isolation is a significant factor in poor performance. In General Practice, this risk can be ameliorated by federation of practices and premises and co-location of primary care services. We have agreed a set of principles with the CCGs to support this direction of travel.

44. We believe that we have a robust system of appraisal and revalidation in place in Kent and Medway, which we will continue to develop in conjunction with our lead appraisers. The system is appropriately quality assured and assists with raising quality of primary care and in triangulation of any concerns that are raised.

45. In summary, our quality ambitions for primary care focus on ensuring a more positive experience of [integrated] care for patients by:

Ambition	**Date**
Full implementation of the Friends and Family Test (FFT) in primary medical, dental, optical and pharmacy services; ongoing improvement in the proportion of positive recommendations to friends and family by people receiving NHS treatment for the place where they received this care.	Mar-15
Use of the FFT to drive improvement in patient experience, both at the relevant touch points in primary care, but also as part of a higher systematic approach, linked to QSG, to support identification and action required to improve patient experience along pathways.	2015/16
Improved satisfaction with the quality of consultation, overall care and access to primary medical services as measured by the annual GP Survey]	2015/16
Reduction in the incidence of avoidable harm attributed to primary care services; HCAIs, medication errors, delayed diagnosis, etc.. • Open and honest cultures across primary care • Reduction in complaints	2014/15 – 2015/16

• Improvement in the proportion of positive recommendations to friends and family by people receiving NHS treatment for the place where they received this care • CQC compliant primary care services	
• Competent primary medical care workforce that has accessed multi-agency safeguarding training • A primary care workforce that is fully engaged in, and learns from, Serious Case Reviews and Domestic Homicide Reviews • Reduction in safeguarding incidents • CQC compliant primary care services	2014/15 – 2015/16
All reviews required by Winterbourne Concordat are undertaken and people are appropriately placed	June 2014

Quality in health and justice

46. To improve the quality of health and justice services and to keep patients as safe as possible from avoidable harm, our areas of focus are to:

- Improve the governance of health care in health and justice settings, including all providers and prison authorities to ensure high quality care pathways.
- Continue to ensure that the quality of health and justice is well governed by the area team, including the continued development of the Health and Justice Quality Group.
- Improve the provision of continuous professional development for all professionals in health and justice settings working with RCGP, national clinical reference group for Health and Justice and Health Education England.
- Ensure robust systems for the appointment of clinical reviewers, which include training, are in place.
- Support providers in the reporting of incidents and serious incidents to promote safety and learning.
- Actively influence the quality specifications for all health and justice commissioning especially the new NHS commissions.
- Ensure a timely and robust process is in place for the investigation of deaths in custody

47. In summary, our quality ambitions for health and justice commissioning will focus on:

Ambition	**Date**
All prisons we commission from have partnership quality governance meetings that include all healthcare providers and prison governors to ensure safety and	All be in phase 2 by March 2015

quality.	
All prison settings report incidents and serious incidents; share investigations and learning. Learning forum for serious incidents in place, to support the development of a culture of learning and improvement.	For all health and justice directly commissioned services by March 2015
Future ambition zero tolerance for death in custody due to suicide for prisoners on ACCT The bank of Clinical reviewers for death in custody is increased and linked to standards for clinical review.	December 2014
The RCGP secure environment group revised guidelines are considered for inclusion as quality standard	2015/16
Improvement in quality of care in Sexual Assault Referral Centres (SARCs), including improvements in the timeliness and availability for all relevant assessment treatment (e.g. paediatric assessment, safeguarding, self-referrals and HIV and hepatitis prophylaxis).	March 2015
Ensure appropriate healthcare skill mix and competency levels in custody suites, with clear service pointers / triggers for public health intervention i.e. alcohol abuse support	2015/16

Quality in public health

48. To improve the quality of the public health services commissioned by NHS England (Kent and Medway) and to keep patients as safe as possible from avoidable harm, our areas of focus are to ensure that:

- All services are commissioned in line with revised national service specifications and monitored through robust clinical governance frameworks (i.e. Kent and Medway Programme specific clinical committees),
- Programmes participate in the national public health quality assurance programme and that learning and feedback from national Quality Assurance team is acted upon.
- Any quality concern identified through the screening and immunisation committees and the national quality assurance report are acted upon and information shared appropriately – i.e. Kent and Medway Quality Board, relevant CCG and Local Authority.
- All providers use Serious Incident reporting frameworks and that incident reporting and investigation is robustly managed with findings and lessons learned acted upon to improve services and programmes.
- Incident reporting and investigation involves all relevant organisations, Public health England, commissioners, Local authority and providers.

- Joint working strengthened cross directorates and teams within NHS England (Kent and Medway).
- The Health Visiting Programme is delivered in collaboration with providers, improving outcomes for children and families as part of the transition towards responsibilities being passed to local authorities in October 2015.

SECTION 4: PUBLIC HEALTH SERVICES (e.g. national screening and immunisation programmes, public health services 0-5 years)

49. Responsibility for the commissioning of public health services is split between Public Health England (PHE), local authorities and NHS England.

50. It is NHS England's responsibility to commission a number of public health services as agreed with the Department of Health and built into the Government's Mandate to the NHS and the NHS Outcomes Framework. An agreement between the Secretary of State for Health and NHS England, made under Section 7a of the National Health Service Act 2006, details the public health commissioning functions that are carried out by NHS England. Known as the '7A agreement', these services sit within a number of programmes:

    a) Immunisation programmes
    b) Screening programmes
    c) Cancer screening programmes
    d) Children's public health programmes (Healthy Child Programme pregnancy to age five)
    e) Child health information systems
    f) Public health services for people in prison and other places of detention including those held in the young people's secure estate
    g) Sexual assault services

51. These programmes are nationally mandated supported by thirty-two national service specifications.

Strategic intent

52. NHS England's ambition is that everyone has greater control of their health and their wellbeing. We want everyone to be supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and continually improving.

53. The summary plan for public health is included as Attachment 1. The public health services commissioned by NHS England directly support the achievement of the NHS outcomes framework domains and ambitions, in particular:

Domain 1 - Prevent premature deaths and increase life expectancy	The preventative immunisation and screening programmes enable interventions to stop people from dying prematurely, securing additional years of life for people with treatable conditions (outcome ambition 1).
Domain 2 - People with LTCs get the best possible quality of life	Screening programmes support the early identification of health conditions, enabling people to receive treatment and support much sooner, improving their quality of life (outcome ambition 2). Immunisations (such as the flu vaccine) can also improve the quality of life for those in particular at-risk groups. In addition, early diagnosis can

	ensure more planned and integrated care can be put in place, reducing avoidable hospital stays (outcome ambition 3).
Domain 4 - Patients have a great experience of their care	Continual performance management, working with providers and other partners, ensures the highest standards of patient experience from the public health services we commission.
Domain 5 – Patients in our care are kept safe and protected from all avoidable harm	Keeping patients safe from avoidable harm is the core purpose of our public health services.

Roles and responsibilities

54. Responsibility for commissioning public health services is commissioned by a number of key bodies:

NHS England	Is accountable for letting contracts and ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. We are responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.
Public Health England(PHE)	Develops the national standards and operational guidance and provides expert leadership and advice to NHS England teams. They also play a leading role in collecting and sharing data and monitoring quality assurance.
Local authorities	In addition to leading the local public health system, they provide information, advice and scrutiny on the public health arrangements of NHS England, PHE and providers through local programme boards and health and wellbeing boards. They also commission sexual health services where some cervical samples are taken and public health programmes for children and young people aged 5-19 years, including the school nursing service which carry out school based immunisations. From October 2015 commissioning responsibility for public health programme covering pregnancy to five years old will transfer to local authorities.
CCGs	Are responsible for quality improvement in services delivered by GP practices, such as immunisation and screening services. As commissioners of treatment services for patients who receive positive screens, they have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen-positive patients and meet quality standards. CCGs also hold the contracts for maternity services which provide antenatal and newborn screening.

Partnership working

55. The *Immunisation and Screening National Delivery Framework and Local Operating Model* sets out clear guidance for the commissioning of the 7A public health programmes. It also covers working arrangements between the embedded Public Health England Screening Immunisations Teams and NHS England. Alongside this guidance, there continues to be a need for continual close working between all the organisations responsible for public health at a local level. The implementation of the national service specifications needs to be carried out in collaboration with CCGs and local authorities to reflect local need.

56. The complex public health commissioning arrangements mean that effective partnerships and continual collaboration between all organisations responsible for public health at a local level, including CCGs, are essential in order to ensure that implementation of national service specifications reflects local need.

57. Joint working is between area teams, local authorities and CCGs to identify areas of inequalities and address variation in uptake and coverage across communities will be critical to success in increasing access, information and choice, in particular for disadvantaged communities.

58. While the commissioning of all national immunisation and screening programmes is undertaken by NHS England, certain elements (such as antenatal and newborn screening services) are included in contracts led by primary care contracting, CCGs, specialised commissioners and in some cases local authorities (e.g. sexual health service contracts). Strong links are needed between area teams and these contract leads to ensure the strategic commissioning requirements of immunisation and screening programmes are addressed through these contractual routes.

59. Joint working is also important with the commissioners of treatment pathways (e.g. paediatric services for children identified with congenital hip dysplasia or ophthalmology outpatients in the case of the diabetic eye screening programme) to ensure that any changes through re-tendering of services do not adversely affect the referral pathway for screen-positive patients.

Priorities

60. Everyone Counts sets two overarching ambitions for public health commissioning:

- to increase the pace of change for the full implementation of the national service specifications; and
- to set performance 'floors' to address unacceptably low performance by local providers.

61. The guidance sets out the following priorities to achieve these ambitions:

- New trajectories for roll out of the family nurse partnership and the health visitor programmes
- A revised specification for pneumococcal vaccination
- The roll out of the pilot introduction of HPV testing in women with mild/borderline changes in their cervical screening
- Revised performance baselines for bowel and diabetic eye screening
- The extension of the bowel screening programme for men and women up to age 75

- A minor change to the service specification for seasonal flu
- A meningitis C catch up programme for university entrants
- The continuation of a time-limited MMR campaign for people over 16 and a catch-up campaign for teenagers
- The continuation of the temporary programme for pertussis for pregnant women
- The implementation of DNA testing for sickle cell and thalassemia screening
- A shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds
- Developments for sexual assault referral centres to develop the service and make it more equitable

62. In addition, NHS England intend to extend flu vaccinations to all children over time. Plans are subject to an assessment of NHS England's commissioning capacity and the development of robust workforce models for delivery of the programme which will be completed in early 2014 and will be confirmed through a variation to the section 7A agreement. Prior to this, NHS England shares the ambition to offer vaccines to all children between 2 and 4 years old and as many secondary school aged children as possible in 2014/15.

63. Attachment 1 provides details of the local commissioning intentions that relate to these national requirements.

64. *Everyone Counts* identifies a number of key performance indicators for public health commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
EF1	Do the plans ensure that Dtap / IPV / Hib (1 year old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19.	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF2	Do plans ensure that MenC (1 year old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19	The planned performance level is above the 93% threshold set in the *Everyone Counts* technical guidance
EF3	Do plans ensure that PCV vaccination coverage (1 year old) will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF4	Do plans ensure that Dtap / IpV / Hib (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

EF5	Do plans ensure that PCV booster (2 years) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF6	Do plans ensure that Hib / MenC booster (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF7	Do plans ensure that MMR for one dose (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF8	Do plans ensure that MMR for one dose (5 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF9	Do plans ensure that MMR for two doses (5 years old) vaccination coverage will meet the national standard throughout 2014/15 and 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF10	Do plans ensure that Hib / Men C booster (5 years) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF11	Do plans ensure that Hepatitis B (1 years old) vaccination coverage will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance. However, it should be noted that there are significant data accuracy issues. However, locally we are confident we will hit the target threshold as we have developed a local monitoring system.
EF12	Do plans ensure that Hepatitis B (2 years old) vaccination coverage will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance. However, it should be noted that there are significant data accuracy issues. However, locally we are confident we will hit the target threshold as we have developed a local monitoring system.
EF13	Do plans ensure that HPV vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF14	Do plans ensure that PPV vaccination coverage will meet the national standard throughout	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

	2014/15 to 2018/19?	
EF15	Do plans ensure that Flu (aged 65+) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF16	Do plans ensure that Flu (at risk individuals) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	Delivery of this target remains a challenge and alternative means of delivering these vaccinations are being established (e.g. beyond reliance on the patients GP). Plans are informed by timely acquisition of data and analysis and understanding of the position is improving.
EF17	Do plans ensure that the percentage of pregnant women eligible for infectious disease screening who are tested for HIV will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF19	Do plans ensure that the percentage of pregnant women eligible for antenatal sickle cell and thalassemia screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF20	Do plans ensure that the percentage of babies who are eligible for newborn blood spot screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF21	Do plans ensure that the percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks or 5 weeks will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF22	Do plans ensure that the percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth will meet the national acceptable standard throughout 2014/15 to 2018/19?	There is currently no reliable data collected across most of England against this target. Therefore, it is not possible to offer assurance that this target will be achieved, However, it is part of the local workplan to implement this programme in line with national guidance and work with providers, maternity commissioners, national and local colleagues to improve data

		collection.
EF23	Do plans ensure that the percentage of those offered screening for diabetic eye screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF25	Do plans ensure that breast cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF26	Do plans ensure that cervical cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is currently not indicating that the threshold set in the *Everyone Counts* technical guidance will be met. Performance dipping below the 80% threshold is part of a long term downward trend nationally. Despite local actions this trend has not altered for Kent and Medway. In order to improve this there will need to be significant resource deployed in media campaigns, health promotion and publicity and targeting of GP surgeries. NHS England (Kent and Medway) will seek to work with national and local colleagues to address this under-performance.
EF27	**Do plans ensure that bowel cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?**	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF28	What number of family health service visitors are planned from 2014/15 to 2018/19?	The planned level of performance is in line with agreed trajectories: **Year** — **No. of Full Time Equivalents (FTEs)** 2014/15 — 421 2015/16 — 421 2016/17 — 421 2017/18 — 421 2018/19 — 421

65. The financial context for public health commissioning is covered next in this plan. Significant financial pressures remain in the public health budget and these have the potential to disrupt service provision and the delivery of the performance trajectories outlined in the above table. The planned performance detailed in this document is subject to the financial pressures being resolved.

Financial context

66. By commissioning effective screening and immunisation programmes with improved coverage and up-take, the public health programme will contribute to delivering financial efficiencies across the health economy by disease prevention, reduced incidence and early identification of cancers (e.g. breast bowel and cervical cancers) and life threatening disease e.g. abdominal aortic aneurisms.

67. The public health team will ensure that all commissioned programmes demonstrate value for money and that high quality, evidenced based cost effective services are delivered including:

    - introducing relevant public health CQUIN (Commissioning for Quality and Innovation payments) targets to new contracts, including reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease;
    - identifying risk of disease and disability early through the commissioning of safe and effective screening programmes;
    - working with providers to demonstrate the value of the universal Healthy Child Programme to improve life chances and access to services for children and families through Health Visiting and Family Nurse Partnership Programmes;
    - ensuring commissioned services represent best value for money and are evidence based;
    - benchmarking the payment and contracting mechanisms of our commissioned services within our Area Team and beyond to ensure and equity of provision;
    - reprocurement of schools based immunisation teams for Kent and Medway; and
    - using revised data sets to ensure screening programmes (e.g. newborn blood spot first and second line testing) is costed on the basis of accurate birth data.

68. In 2013/14, a surplus of £0.5m is projected. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent deficits are carried forward.

69. There are a number of cost pressures arising out of national directives, funded by new allocations. This includes meningitis C (University) and childhood influenza programmes. The expansion of the Family Nurse Partnership (FNP) scheme, the full year costs of the increase in health visitors and the additional cohorts in 2014/15 have also been fully funded. Funding has been received for delivering an extension to the bowel screening programme. However, the funding received is less than the expected costs of these programmes and the shortfall has been included as an unfunded risk.

70. The costs of the 15 % QOF previously chargeable to public health is now included under primary care, for which a transfer of allocation has been made.

71. The overall effect of these cost pressures and changes is to generate a deficit of £2.4m, which reflects a movement of £2.9m from the 2013/14 outturn. This is attributed to the cost of vaccines charged by the NHSBSA which were deducted from CCG budgets by the Department without passing the funding on to Area Teams. The target position is to break even.

72. The summary financial position is shown below:

Public Health		
	2014/15	**2015/16**
Previous year outturn	51,516	53,966
Part year effects	-3,733	-980
Sub total	47,783	52,986
Inflation uplifts	908	1,343
Growth	442	317
Provider Efficiency	-365	-1,483
Service Investments	5,198	1,841
QIPP	0	0
Total	**53,966**	**55,003**
Notified Allocation	51,314	51,314
Deficit carried forward	209	-2,443
Total Resources	**51,523**	**48,871**
Variance Surplus (+) / Deficit (-)	**-2,443**	**-6,132**

SECTION 5: HEALTH AND JUSTICE HEALTHCARE SERVICES (e.g. healthcare services provided in secure estate settings such as prisons)

73. NHS England (Kent and Medway) commission healthcare services for people in prison and other justice settings across Kent, Surrey and Sussex.

74. We are also working to ensure the timely and effective transition of commissioning responsibility for healthcare in Immigration Removal Centres, Police Custody Suites, Children and Young Peoples Secure Training Centres, Secure Children's Homes (welfare only) and Sexual Assault Referral Services is moving apace. On-going work is underway to develop and implement national service specifications and key Performance Indicator (KPI) monitoring data suites covering the delivery of healthcare services in secure estate settings, such as prisons.

75. Identifying and responding to issues of quality and safety for patients has been a resource intensive element of this programme of work. Resulting in some necessary reprocurements. The successful implementation and 'bedding in' of new contracts into some settings are a priority – particularly where delivery of healthcare services by the Prison Service has recently been transferred to a new healthcare Provider.

76. Increasing coverage of the Police and Court Liaison and Diversion Service across Kent, Surrey and Sussex remains a priority and the need to embed the patient voice and their involvement in our commissioning cycle continues to require dedicated time and planning.

77. Implementation of new IT systems for prescriptions, smart cards and the refresh of national systems (e.g. System1) are important to maintain infrastructure in our prisons and manage risk.

78. Maintaining a visible presence in the settings that we commission services for has added valuable and provides visible leadership for our partners and helps us as commissioners gain real insight into how services are delivered and experienced by users.

Strategic intent

> *"True justice for the most vulnerable is about pulling people into treatment, not pushing them away from the support they need. People should get the same quality of services in prison as they do in the community...we have to do more in early intervention, to support children and young people before they reach crisis point...we need diversion services to be a cornerstone of better care and support for offenders with mental health problems"*
>
> The Secretary of State for Health, speaking about health and justice commissioning at a joint event with the Ministry of Justice, March 2011

79. NHS England aims to commission services that offer care of the very highest standard and the best health outcomes for people in prisons and other justice

settings. Ensuring that these people receive the same standards of care that they would in the community is a core principle that underpins our approach. In addition, we want to drive quality improvements in the care and outcomes delivered. The summary plan for health and justice is included at Attachment 2.

80. Through the services we commission, we want to make progress towards the government's objectives of reducing violence - in particular by improving the way the NHS shares information about violent assaults and supports victims of crime - and developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community.

81. People in prison and other justice settings tend to have poorer health and worse health outcomes than the average population. We will work, together with out partners, to commission services in ways that will help to tackle these inequalities. In addition, we will continue to develop our commissioning approach in response to the *Bradley Report*'s recommendations to address the over-representation of people with mental health problems in prisons.

82. Through a single operating framework (developed jointly with the National Offender Management Service, Public Health England, Youth Justice Board, Home Office Immigration Enforcement and Police Custody Healthcare) we are responsible for commissioning health services in the following places:

- Prisons
- Young offender institutes
- Secure children's homes
- Immigration and removal centres
- Police custody suites
- Court liaison services

Roles and responsibilities

83. Responsibility for commissioning health and justice services is shared between the NHS England, CCGs and local authorities:

NHS England	Responsible for the direct commissioning of health services for people who are detained. Also responsible for some public health services (such as substance misuse services) for prisons. Area teams may devolve this responsibility to existing local joint commissioning arrangements in order to support more joined up services and continuity of care where they are satisfied that this will deliver their required outcomes.
CCGs	Responsible for commissioning health services for people engaged with the justice system but not in detention. Have a duty to co-operate in multi-agency youth offending teams. CCGs also responsible for commissioning emergency care services for "every person present in its area" including those in detention.
Local	Responsible for commissioning many public health services for people in their

authorities	area including those engaged with the justice system. Local authorities also commission sexual health services that may be used by victims of sexual assaults.

Partnership working

84. Effective partnerships are crucial to enable us to achieve our aims of commissioning excellent, equitable, integrated health services that deliver the best outcomes for people engaged with the justice system.

85. Partnership working already exists through local prison partnership boards and health and criminal justice boards, bringing together NHS England, CCGs, prisons, the police, local authorities and NOMS. These partnerships are able to ensure the effective use of resources, support continuity of care during the transition from custody to the community and can monitor and support equity of access.

86. These partnership approaches need to be further developed and expanded to ensure they are able to reflect the increased focus on the integration of services and the inclusion of reducing re-offending rates and other related indicators in the public health outcomes framework. However, it is also important to streamline governance arrangements to reduce the number of meetings that take place in recognition of the reduced management resource.

87. The NHS England, CCGs and local authorities (public health, children's services and social services) need to work together to commission integrated pathways of equitable health and social care for people whose lives intersect with justice services and to develop outcomes aligned to local joint strategic needs assessments and health and wellbeing strategies.

88. For the majority of people in prisons and other justice settings, their engagement with these services is temporary. Most will transition back to the community, although some will go back and forth. To ensure the best, most equitable health and outcomes for them, it is essential that health and justice services are not commissioned in isolation, but are seen as part of a continuum with the services these individuals would receive in their local community.

Priorities

89. The key priorities in commissioning for health and justice from 2014/15, set out in the Everyone Counts, are:

- To ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of resettlement prisons.
- To support sustainable recovery from addiction to drugs and alcohol and improved mental health services.
- Promotion of continuity of care from custody to community and between establishments, working closely with probation services, local authorities and CCGs.

- Development of a full understanding of the healthcare needs of children and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs.
- Continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme.
- To ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.
- A number of developments for sexual assault referral centres to develop the service and make it more equitable (listed as a public health ambition in the *Everyone Counts* five-year strategy planning guidance).

90. Commissioning plans for the next five years need to address these priorities. They also need to be flexible, with contracts capable of being adapted to meet changing circumstances and any shifts in the policy directions of the various external bodies and agencies involved in health and justice. For example, changes in the use of the custodial estate (for example from a prison to an immigration and removal centre) can happen at short notice, leading to a fundamental change in the health needs profile of the people who will be accommodated there.

91. Commissioners also need to consider the on-going development of the market for the provision of healthcare in justice settings, ensuring that there are sufficient providers able to offer quality, innovation and value for money.

92. Commissioners need to commission innovative solutions to challenging problems, seeking solutions in a different way. Locally this will mean exploring the potential use of telemedicine within prisons in order to reduce the need for costly and timely escorts and bed watches and in term reduce delays in receiving secondary healthcare out-patient care.

93. Attachment 2 provides details of the local commissioning intentions that relate to health and justice services.

94. *Everyone Counts* identifies a number of key performance indicators for health and justice commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
EG1	Do plans ensure that the national standard for health commissioned services for long term conditions will be delivered throughout 2014/15 to 2018/19?	Each prison now has a Health Improvement Plan (HIP) shared across all Providers and reported on at quality meetings. The development of a bespoke long term condition strategy for each prison forms part of the HIP. We are confident of delivery within the required standards.
	Do plans ensure waiting times will be delivered throughout 2014/15 to 2018/19	NHS England (Kent and Medway) has indicated this standard around waiting times for treatment for individuals in secure estate will not be met. Enabling prisoners to access secondary care is a significant challenge nationally due to the number of escort and bed

		watches cancelled by prisons due to staff availability. A number of streams of works are in place to support the delivery of this target including : - We have commissioned a review of telemedicine to support the delivery of this target but this will not report until summer 2014. - We will liaise with regional and national colleagues to explore the feasibility of a national MOU between NOMS and NHS England to reduce cancellations (e.g. by improving the availability of escorts and bed watches). - We are also sharing data and concerns directly with NOMS as impacting on delivery of timely healthcare. - We are discussing with Acute Providers appointment times for prisoners that best match the prisons 'core day' regime to maximise opportunities for attendance. - Ensuring providers have formal call back processes if prisoners fail to attend appointments.
EG3	Do plans ensure that the national standard for patients with a learning disability will be delivered throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EG4	Do plans ensure that the national standards for patients under Section 117 will be delivered throughout 2014/15 to 2018/19	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

Financial context

95. In 2013/14, a surplus of £1.7m is projected, arising from a combination of delayed starts to schemes, reduced demand for substance misuse services and other savings. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent surpluses are carried forward.

96. The service has received an increase in allocation, including 2% for growth and additional funding for developing liaison and diversion services, sexual assault referral centres (SARCs) and prison reconfigurations. In addition to these developments, there are also improvements in the provision of primary care in some prisons and the responsibility for some services in immigration removal

centres (IRCs) is expected to transfer from the Prison Service, although no funding has yet transferred. The cost of these services is marginally less than the growth funding received and savings identified, hence the surplus increases to £2.0m, achieving a surplus in excess of the 1% target.

97. The summary financial position is shown below:

Health & Justice		
	2014/15	**2015/16**
Previous year outturn	44,521	47,079
Part year effects	0	-246
Sub total	44,521	46,833
Inflation uplifts	870	1,358
Growth	8	392
Provider Efficiency	-129	-111
Service Investments	2,623	257
QIPP	-815	0
Total	**47,079**	**48,729**
Notified Allocation	49,111	49,338
Surplus carried forward	0	2,032
Total Resources	**49,111**	**51,370**
Variance Surplus (+) / Deficit (-)	**2,032**	**2,642**

SECTION 6: PRIMARY CARE SERVICES (e.g. core services from general practitioners, community pharmacies, dentists and optometrists)

98. The delivery of core primary care services is largely covered through nationally negotiated contracts (e.g. general medical services (GMS) contracts) or nationally determined regulations (e.g. regulations governing the process for reviewing applications to open a new community pharmacy).

99. Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping recovery from episodes of ill health and injury. Primary care professionals are best placed to make effective preventative interventions and to impact positively on the quality and efficiency of the whole health service.

Strategic intention

100. NHS England's ambition is to deliver, through excellent commissioning:

- A common, core offer for patients of high quality patient-centred primary care services.
- Continuous improvements in health outcomes and a reduction in inequalities.
- Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda.
- The right balance between standardisation/consistency and local empowerment/flexibility.

101. This document should be read in conjunction with NHS England (Kent and Medway)'s draft Strategic Framework for Primary Care.

102. The recently published "Improving General Practice - A Call to Action Phase1 Report" sets out 5 ambitions for general practice and wider primary care. The ambitions are:

- Proactive, coordinated care
- Holistic, person centred care
- Fast, responsive access
- Health-promoting care
- Consistently high quality care

103. We can achieve this ambition and vision through our new commissioning arrangements, our approach to engaging with and understanding our patients, strengthened primary care clinical leadership and by developing innovative approaches that challenge the ways of the past.

104. A clear case for change, coupled with a desire from general practice to transform services, has emerged and has been reinforced through the *Call to Action* on

primary care:

- Population changes - including an aging population, an increase in people living with multiple long term conditions and changing public expectations – are increasing demand for health services.
- Improving our primary care services will improve patient care and will cost less. Better care, closer to home is the only way to maintain quality of care in the face of increasing demand and limited resources.
- Addressing inequalities in access, quality and outcomes will require new and innovative ways of coordinating services.
- Action is needed to address emerging workforce pressures including recruitment and retention problems for GPs and practice nurses.

105. NHS England (Kent and Medway) believes the areas discussed in this plan (and in our Draft Strategic Framework for Primary Care) can be used to draw some conclusions on the future configuration and role of general practice. These conclusions are emerging and will need to be kept under ongoing review.

106. A federated model of general practice, delivering integrated primary care services to large populations and communities, would appear to be a potential solution to the future configuration and role of general practice. This is an emergent approach that has been proposed by the RCGP and others within the profession.

107. It is suggested that general practice is on a journey that will take it along a development path, progressing through a number of stages:

i. Current state

ii. An extended skill mix in practices and across a range of primary care providers

iii. Federation of practices

iv. Co-location of practice / merger of practices to form larger partnerships / primary care units

v. Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations)

108. The Everyone Counts sets out the following key characteristics of high-quality care in primary care:

- Proactive coordination of care, particularly for people with long-term conditions and more complex health and care problems.
- Holistic care: addressing people's physical health, mental health and social care needs in the round.
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing.
- Involving patients and carers more fully in managing their own health and

care.

- Ensuring care is of a consistently high quality: effective, safe and with a positive patient experience.

109. The following table provides more detail of the strategic intentions for the key primary care services:

General practice	General practice is the cornerstone of the NHS. Improving the nature of services provided outside hospital and supporting the public in self-care will be key ingredients for a sustainable NHS. Transformation in general practice must seek to maintain the internationally recognised strengths of the general practice model. Improving access is a priority, ensuring prompt access to GP services through 111, services that are available from 8am to 8pm seven days a week, and more rapid response to patient concerns through the use of telephone consultation. There will also be more personalised care and equality of access to services for everyone irrespective of where they live or their social status. We will work with CCGs, providers and other partners to identify and address inequalities. To achieve these ambitions will require a more scaled-up approach to general practice. This will mean working towards fewer, larger practices or federations or groupings of smaller practices where expertise is pooled and there can be increased focus on efficiency and innovation. This will enable patients to have seven-day-a-week access to a greater range of high quality primary care services. There will also need to be increased capacity in general practice and workforce plans need to include realistic projections for the number of GPs and practice nurses required, taking consideration of the presently aging workforce and changes in the career aspirations and expectations of newly qualified staff. Data and information are fundamental to providing high-quality, personalised care, improving productivity and empowering patients and clinicians to transform local services. It will be essential that GPs are supported by effective, efficient and integrated information technology systems. Patient access to electronic health records has been shown to improve health outcomes and reduce workload and costs so in line with the national strategy this will be supported. Online consultations in selected situations are also proving safe, effective and can improve patient confidentiality while reducing costs so will be facilitated. Primary care services operate within communities and have strong links with the voluntary sector and community services. Strengthening and further integrating these can ensure resilient healthy communities addressing the root causes of ill health.
Community pharmacy services	Community pharmacy will be increasingly used for urgent minor complaints, as part of an integrated urgent and emergency care system, reducing the pressure on general practice and A&E.

	Working with the LPC to ensure that we have the right number of pharmacists, with the right roles, working from the right locations will be important if we are to take advantage of the opportunities to provide a wider range of professional services from community pharmacies. Call to Action has also identified with the LMC an opportunity for pharmacists to undertake a more clinical role as part of the primary care team. Increased mechanisation of dispensing will be supported to free up time for more proactive health interventions.
Dentistry	NHS England commissions dental services in both primary and secondary care, providing an opportunity to commission services across the whole patient pathway. We will look to move work such as minor oral surgery out of secondary care to primary care where we can so it is closer to home and more convenient for patients. We will also work with primary care dental providers and through the LPC to ensure that referrals continue to be made and handled appropriately.
Optometry	Many services provided in secondary care ophthalmology, such as for glaucoma and special needs optometry, could be carried out more efficiently and conveniently in high street optometry services. Core contracts for optometry will be developed and refined with the LPC and we will work with CCGs to co-commission services that can be moved from secondary to primary care.

Partnership working

110. Our aim is to create sustainable NHS services that provide more integrated care for patients, built around the registered populations served by groups of practices. To do this NHS England is developing joint arrangements for commissioning with CCGs and also with local authorities who hold some primary care contracts.

111. It is important that this co-commissioning approach is developed to ensure the right balance between standardisation and flexibility in order that local primary care services can be planned in the context of CCGs' commissioning strategies, health and wellbeing strategies, JSNAs, PNAs and so citizens and communities can influence and challenge how services are provided.

112. Local professional networks (LPNs) for pharmacy, dentistry and eye health have been established and chairs appointed. As the committees' work gets underway it is essential that they support NHS England in commissioning these services by ensuring representative and robust clinical input to decision making and leading the profession in peer review and support, maximising performance, addressing inequalities and driving continuous improvement.

113. We will work with Health Education England to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment.

Primary care support services

114. NHS England is responsible for primary care support (PCS) services and wants all practitioners to have access to a standard range of modern, efficient and effective PCS services without the current variations in quality and cost. NHS England is continuing to work with staff and stakeholders to achieve the required changes in PCS services.

Secondary care dental

115. National criteria and care pathways are currently being developed by NHS England for all dental specialties following which commissioning of secondary and primary care services will be reviewed. Until these are in place steady state commissioning will continue with existing providers.

116. There are currently no CQUIN specifically for dentistry and these are to be developed at a national level; the 2014/15 CQUIN indicators that Kent and Medway will be using relate to collection of the relevant data flows to enable these to be developed.

117. Referral management arrangements are in place for oral surgery and endodontic treatment as ongoing QUIP delivery. Once national care pathways are in place, it is anticipated that further referral management will be introduced for other dental specialties.

Priorities

118. For general practice services a number of changes have been agreed to the national GMS contract, including:

- **Having a named, accountable GP for people aged 75 and over.** As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.
- **Out-of-hours services.** There will be a new contractual duty for GPs to monitor and report on the quality of out-of-hours services and support more integrated care, e.g. through record sharing.
- **Reducing unplanned admissions.** There will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:

- improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
- ensure that other clinicians and providers (e.g. A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions;
- carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management;
- provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator;
- work with hospitals to review and improve discharge processes; and
- undertake internal reviews of unplanned admissions/readmissions.

- **Choice of GP practice.** From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits. This will give members of the public greater freedom to choose the GP practice that best meets their needs. NHS England's area teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.
- **Friends and Family Test.** There will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.
- **Patient online services.** GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments for local GP practices.
- **Extended opening hours.** The extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access to services.
- **Patient participation.** The patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.
- **Transparency of GP earnings.** The British Medical Association's General Practitioners Committee (GPC) will join a working group with NHS England and NHS Employers to develop proposals on how to publish (from 2015/16 onwards) information on GPs' net earnings relating to the GP contract. The first published data would be based on 2014/15 earnings and publication of this information will be a future contractual requirement.

- **Diagnosis and care for people with dementia.** There will be changes to this enhanced service to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.
- **Annual health checks for people with learning disabilities.** There will be changes to this enhanced service to extend its scope to young people aged 14-17 to support transition to adulthood and to introduce health action planning.
- **Alcohol abuse.** There will be changes to this enhanced service to incorporate additional assessment for depression and anxiety.
- **Support for innovation: Innovation pioneer hub** (Robert Stewart's work which we can share)

119. Locally, NHS England (Kent and Medway) is committed to ensuring patients can access high quality GP services that meet the needs of our local communities. We will work with CCGs and other stakeholders to review and either extend (where there is flexibility to do so), reprocure or decommission those existing Alternative Provider of Medical Services (APMS) contracts and services which are scheduled to end at various points during the next two years (up to 31st March 2016). The following APMS contracts are scheduled to end during the next two years are:

Practice Name	CCG Area
DMC Sheppey Healthcare Centre	Swale
DMC Walderslade Surgery	Medway
College Health-Boots	Medway
College Health –Sterling House	Medway
DMC Medway Healthcare Centre	Medway
The Broadway Practice	Thanet
White Horse Surgery and Walk-In Centre	Dartford, Gravesham and Swanley
Minster Medical Centre	Swale
The Sunlight Centre	Medway

120. NHS England (Kent and Medway) has a relatively high percentage of general practices on General Medical Services (GMS) contracts. In this respect 82% of GP contractors across Kent and Medway hold GMS contracts with only 13% of practices holding Personal Medical Services (PMS) contracts and a further 5% holding APMS contracts. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health and NHS England from 2014/15) and the General Practitioners Committee (on behalf of the BMA).

121. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to patient need, as well as CCG and NHS England strategies. A local review of

PMS contracts was undertaken throughout 2012/13 by the former Cluster PCT. This resulted in the vast majority of PMS contracts being successfully reviewed. A further review of PMS contracts across Kent and Medway will be undertaken in three phases:

- Phase 1 will be to facilitate any transfer back to a GMS contract that PMS contractors wish to make.
- Phase 2 will be to comprehensively review those contracts where the previous review was not concluded to the satisfactions of the NHS England.
- Phase 3, which will be undertaken in 2015/16, will be to review the objectives of other PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.

122. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Reviewing and, if appropriate, reprocuring the occupational health service for GPs and other primary care contractors.
- Working with local authorities to support them to develop more healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Extending the delivery of flu vaccinations in community pharmacies in order to help boost take up of the vaccine amongst at risk patients.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.
- Reviewing and where appropriate reprocuring interpreting services to support patients in accessing primary care contractor services.

123. *Everyone Counts* identifies a number of key performance indicators for primary care commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
ED1	What is the planned satisfaction with the quality of consultation at GP practices throughout 2014/15 to 2018/19?	Satisfaction with GP consultations, care at surgery and access to primary care is expected to continue deteriorating to 2016/17 before recovering. This is felt to be a realistic position reflecting the national trend and the challenges facing general practice in which the current experience of recruitment difficulties, locum utilisation and expected practice closures/mergers which are not necessarily popular with patients and communities. Some structural change is necessary and expected
ED2	What is the planned satisfaction with the overall care received at the surgery throughout 2014/15 to 2018/19?	
ED3	What is the planned satisfaction with access to primary care throughout 2014/15 to 2018/19?	

		and consequently we anticipate it taking 2-3 years to halt the existing downward trajectory in patient experience before we start to see some marginal improvement).
ED5	What is the planned of flu vaccination coverage for those at risk throughout 2014/15 to 2018/19?	
ED6	What is the planned distance between expected depression prevalence and reported depression prevalence from 2014/15 to 2018/19?	This indicator looks at depression prevalence and a trajectory has not yet been set due to data collection problems. This is a national issue and NHS England (Kent and Medway) is working with national colleagues to agree how this should be tackled and the indicator monitored.
ED7	What is the planned percentage of the population which have seen a dentist in the past 24 months for years 2014/15 to 2018/19	The planned level of performance is: Year — % of population who have been seen by a dentist in the past 24 mths 2014/15 — 51.0% 2015/16 — 51.5% 2016/17 — 52.0% 2017/18 — 52.5% 2018/19 — 53.0%
ED8	How many dental courses of treatment are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	Dental treatment rates are unlikely to increase without increased expenditure and this is not built into the plan at this point and, as such, delivery against this target is a risk.
ED9	What is the planned level of positive responses on dental services from the GP Survey from 2014/15 to 2018/19?	The planned level of performance is: Year — % of positive responses 2014/15 — 81.2% 2015/16 — 81.2% 2016/17 — 81.2% 2017/18 — 81.2% 2018/19 — 81.2%
ED10	How many sight tests are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	The local trajectory for sight test shows a very marginal increase in activity volumes per 100,000 population. Detailed plans will be developed in 2014/15 to address this
ED11	How many sight tests are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	This projects a roll-forward of historic activity.

ED12	How many repairs and replacements per voucher are planned to be delivered throughout 2014/15 to 2018/19?	This projects a roll-forward of historic activity.
ED13	How many prisms per voucher are planned to be delivered from 2014/15 to 2018/19?	This projects a roll-forward of historic activity.

General Practice Information Technology

124. General Practice Information Technology (GP IT) covers a broad spectrum of areas. The GP IT operating model 2013/14 provided by NHS England breaks GP IT into three areas:

1. Core and mandated service provision	This includes the following and the hardware required to deliver the services: • GP Clinical systems – new provision and upgrade • GP Extraction Service • Nationally mandated systems e.g. Electronic Prescription Service • Software licenses required – new provision and upgrade • Underpinning Information Governance • Networking and connectivity services required • Hardware required – provision and replacement • Hardware and System maintenance, along with the provision of a service/help desk • Registration Authority services • Core administrative services to underpin the service • Clinical safety and assurance required
2. Local strategic and discretionary service provision	GP IT provision to support local strategic initiatives to improve service delivery and support local commissioning objectives and any items provided under discretionary funding.
3. General Practice business systems service provision	GP IT funded by the general practice or other funding services to support corporate business delivery functions in the GP.

125. Further national guidance on GP IT has just been received and needs to be considered. However, it is highly likely that the capital allocation will not cover the required capital refresh (especially noting that Microsoft will stop supporting Windows XP and a large volume of computers are using this operating system).

This means a key priority is to develop a robust IT strategy for primary care that both enables the benefits of technology to be exploited whilst managing a difficult financial position. In addition, further developing the service support arrangements (e.g. from the Commissioning Support Unit).

126. The desired outputs from the GP IT strategy work have been identified as follows:

- a GPIT strategy document that provides strategic road map for the development and deployment of IT to support General Practices, and underpinning framework(s) for the strategy; and
- a costed actionable plan that describes the strategy in terms of annual priorities and potential programme of work.

Financial context for secondary care dental

127. This service is currently over-performing, although demand management controls are in place to try to contain expenditure. This trend is likely to continue into 2014/15 and this is reflected in the summary financial position shown below:

Secondary Dental		
	2014/15	**2015/16**
Previous year outturn	21,464	21,576
Part year effects	0	-91
Sub total	21,464	21,485
Inflation uplifts	480	623
Growth	214	214
Provider Efficiency	-673	-859
Service Investments	91	88
QIPP	0	0
Total	**21,576**	**21,550**
Notified Allocation	20,480	20,880
Deficit carried forward	-2,260	-3,356
Total Resources	**18,220**	**17,524**
Variance Surplus (+) / Deficit (-)	**-3,356**	**-4,026**

128. Although the 'headline' allocation has increased over 2013/14 levels, the need to absorb the previous year's deficit has led to an increased deficit in the following year. Therefore the forecast outturn in 2013/14 of a £2.2m deficit has increased by approximately a net million pounds in subsequent years.

Financial context for primary care

129. In 2013/14, a surplus of £1.7m is projected. This surplus is carried forward into 2014/15, as are future surpluses and deficits.

130. There are a number of significant changes to reporting of expenditure between 2013/14 and 2014/15. Expenditure on GP IT was included in the spend and allocation in 2014/1. However, the allocation has not been included in 2014/15 and the expenditure has, therefore, been excluded. The public health element of general practice Quality Outcome Framework (QOF) of £5.4m was reported under public health in 2013/14, but is now to be reported under primary care matched by a transfer of allocation.

131. Primary care services are most directly affected by changes in population. GPs' income is largely based on list sizes and demands for pharmacy, dental and ophthalmic services also change as the population changes. Kent & Medway is projecting a 1% annual growth in population and this creates a cost pressure of £2.7m per year. There are also a number of cost pressures arising out of national directives. For example, an Enhanced Service is proposed for a named GP for those aged 75 and over, and there is to be greater choice of GP practice with Area Teams responsible for any in-hours urgent medical care. These initiatives are expected to cost £0.3m per year.

132. Primary care services are subject to annual pay and price increases. The Doctors and Dentists Review Body has recently announced the pay increases for 2014/15. A 1% increase had been assumed, costing £3.3m. Although the overall package is expected to increase income by 1% the actual change to GP fees is an increase of 0.28% and to dental fees is an increase of 1.6%. This has increased the surplus on primary care services by £1.040m.

133. Despite including all these cost pressures there are a still a number of risks which sit outside of the expenditure plans. The principle risk relates to property charges. The rents charged during 2013/14 by Property Services reflected the values included in baseline. Moving to actual rents, plus increased costs since the baseline was calculated, could add a further £1.2m to costs.

134. The allocation has been increased in 2014/15 by 2.42% growth. However, since the carried forward surplus in 2013/14 is greater than that projected to be carried forward into 2014/15, there is a reduction of £1.7m in allocation for this factor. The net increase in allocation is £15.7m. Comparing this to the identified cost pressures produces a surplus of £6.8m.

135. The summary financial position is shown below:

Primary Care		
	2014/15	**2015/16**
Previous year outturn	343,222	348,035
Part year effects	1,818	-2,048
Sub total	345,039	345,986
Inflation uplifts	2,198	2,211
Growth	2,772	2,775
Provider Efficiency	-1	-1
Service Investments	1,082	1,914
QIPP	-3,056	-1,900
Total	**348,035**	**350,985**
Notified Allocation	352,896	359,888
Surplus (+) / Deficit (-) carried forward	1,977	6,838
Total Resources	**354,873**	**366,726**
Variance Surplus (+) / Deficit (-)	**6,838**	**15,742**

SECTION 7: PRESCRIBED SPECIALISED SERVICES AND SERVICES AND ARMED FORCES HEALTH

Prescribed specialised services

136. NHS England (Surrey and Sussex) is responsible for commissioning prescribed specialised services on behalf of the populations of Kent and Medway and Surrey and Sussex. Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Specialised services provided by Kent and Medway providers include:

- East Kent University Hospital NHSFT (£65m, Renal, Cardiovascular Services, Haemophilia)
- Maidstone & Tunbridge Wells NHST (£52m, Cancer Services)
- Kent and Medway Social Care partnership Trust (£18 secure and forensic Mental Health)

137. In addition, to the above Kent and Medway residents access a range of other specialised services in other areas, particularly London.

138. NHS England is committed to ensuring that such services are commissioned on behalf of patients in a nationally coherent and equitable way. Commissioning intentions for specialised services have therefore been developed nationally and can be viewed at: http://www.england.nhs.uk/wp-content/uploads/2013/10/comm-intent.pdf.

139. Six key strategic strands are identified as part of these commissioning intentions:

a. Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.

b. A Clinical Sustainability Programme with all providers, focused on quality (this includes the need to achieve and maintain compliance with full service specifications and to keep these specifications under review in order to deliver a continuous improvement in health outcomes for patients).

c. An associated Financial Sustainability programme with all providers, focussed on achieving better value in the use of NHS resources.

d. A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.

e. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways.

f. A systematic rules-based approach to in-year management of contractual service delivery.

140. Locally, these strategic intentions have been translated into a number of service priorities:

Consolidating cardiovascular expertise	Secure additional years of life by consolidating acute cardiovascular expertise in a reduced number of emergency care centres (e.g. primary PCI and interventional cardiology)
Addressing avoidable admissions / reducing lengths of stay	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, specifically by reducing the need for inappropriate high cost specialised treatment by working with primary care and public health to reduce demand through increasing capacity in primary care to detect and refer people at an early stage.
Efficiency targets	Efficiency targets needs to be set at around 4.5% (£23m) given expected allocation for 2014-15 with the 2015-16 level on a par with 2013-14 outturn without investment
Commissioning for quality and Innovation (CQUIN)	Focusing of local CQUIN schemes on fewer initiatives with clear opportunities for local improvement and performance management. Contract performance management remains challenging without comparable historic and granular current activity data being consistently reported by providers and analysed by Commissioning Support Units

Armed forces health

141. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) commission armed forces health services on behalf of all areas in the South of England, including in Kent and Medway. The identified vision of the team is to provide high quality and safe care for armed forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

142. Armed forces healthcare is for serving members of the armed forces, reservists, veterans and all of their families who form part of a larger 'armed forces community'. In terms of the armed forces population:

- 51% of the population is aged under 30;
- 82% is aged under 40;
- 9.7% of the serving population is female;
- 58% of the serving population is in the army, 20% in the Navy or Royal Marines and 22% in the RAF;
- 17% of the serving population are officers (14% army to 22% RAF); 83% other ranks (78% RAF to 86% army); and
- overall 7.1% of the serving population are from a BME group (2.4% of officers, 8.1% of other ranks).

143. Whilst armed forces healthcare is commissioned by NHS England there are a range of commissioning responsibilities that sit with different statutory bodies:

- **NHS England** – NHS England is responsible for the direct commissioning of secondary and community health services for Armed Forces and families registered with the Defence Medical Service (DMS) Medical Centres. It assumes responsibility for commissioning some public health services through a Section 7 agreement with the Secretary of State, which Armed Forces and their families will be able to access.
- **CCGs** - CCG's are responsible for commissioning health services for veterans and families of members of the armed forces registered with NHS GP practices. CCG's are also responsible for the commissioning of emergency care services for 'every person present in its area', which includes for members of the Armed Forces and their families. It is also recommended that the responsibility for hosting Armed Forces Networks transfer from NHS England by agreement to appropriate lead CCG's to sustain the work of the 10 Armed Forces Networks currently in place. Given the strong focus on veterans and armed forces family healthcare, CCGs are well-placed to lead Armed Forces Networks, with support from NHS England. Further discussions will be needed with Armed Forces Networks to agree their transition and leadership arrangements for the future.
- **Local Authorities** – Local authorities are responsible for commissioning the majority of public health services for people in their area including members of the armed forces, their families and veterans. The exceptions to this are screening services, immunisations, public health services for children aged 0-5 years, public health services for prisoners and other detainees and Sexual Assault Referral Centres (SARCs). These services will be commissioned directly by NHS England. Local authorities will also commission open access sexual health clinics and genito-urinary clinics.

144. Members of the armed forces are typically younger and fitter than the general population. As such, there is low prevalence of long-term conditions but higher incidence of musculoskeletal injury. Combat-related injuries aside, armed forces healthcare needs can usually be met by standard NHS services.

145. The families and dependants of serving armed forces members have health needs typical of their age and gender. Maternity services and children's health services, in particular, must be planned and commissioned with the needs of military families in mind where they are present in large numbers in a community.

146. Members of the armed forces may also have specific health needs that relate to their occupation or employment and require extensive occupational health support. Where the services needed for occupational health exceed the normal NHS services or standards, they will remain the responsibility of Defence Medical Service to commission, pay for or deliver.

147. There is a public perception that the Armed Forces community have a range of mental health problems and in particular suffer from Post-Traumatic Stress Disorder (PTSD). In 2009 the Academic Centre for Defence Mental Health undertook a useful review of evidence on the health and social outcomes - and

the health service experiences - of UK ex-service personnel. Their findings highlighted that:

- the ex-service population has comparable health to the general population and a broadly similar prevalence of mental health-related conditions;
- current UK military personnel have higher rates of heavy drinking than the general population;
- the most common mental health issues experienced by ex-service personnel are alcohol misuse, depression and anxiety disorders;
- military personnel with mental health problems are more likely to leave the armed forces and are at increased risk of adverse outcomes in post-service life;
- the minority who leave the military with psychiatric problems are at increased risk of social exclusion and ongoing ill health;
- the overall rate of suicide is no higher than for the general UK population, with the exception of male veterans aged 24 or younger who are at increased risk compared to their general population counterparts;
- early service leavers are more likely to have adverse outcomes and carry out risk taking behaviours than longer serving veterans; and
- deployment to Iraq or Afghanistan is associated with adverse mental health outcomes for some groups, particularly those with pre-service vulnerabilities, those who experience a high level of combat and reservists.

148. Armed forces commissioning will have a particular focus on those patients with the most complex care needs. NHS England will work to ensure that:
    - a modern model of integrated care is in place;
    - the date of discharge from the armed forces has no impact on the care decisions made, regardless of how far in the future the date may be;
    - area teams facilitate and support a multi-disciplinary team (MDT) approach for those service leavers that have complex health needs or are considered to be a seriously Wounded Injured or Sick (WIS) individual (this may include organising for continuing health care assessments to be made);
    - WIS individuals have an agreed personal health plan prior to service discharge and are clear as to the NHS offer and their rights and responsibilities; and
    - CCGs understand the needs of WIS individuals and their rights under the Armed Forces Covenant.
149. Access to urgent and emergency care. We will work with DMS, Clinical Networks and local CCGs and providers to ensure that:
    - the armed forces community is able to access appropriate services and cost effective out of hours primary care services;
    - the armed forces community is able to access appropriate out of hours services for those in mental health crisis;

- appropriate services are included in NHS 111 directories;
- the views and needs of DPHC are represented at Urgent Care Working Groups, where there is a sizeable Population at Risk (PAR) within the community;
- where there is a sizeable PAR their needs are reflected in the plans that CCGs and Health & Wellbeing Boards agree for the Better Care Fund; and
- the redesign of emergency care systems where there is an associated movement of DMS staff does not result in a destabilisation of providers.

150. NHS England will also be working with DMS, local authorities and colleagues in Public Health, both Public Health England and within NHS England, on the health inequalities agenda. Specific areas of focus are:
    - access to national screening programmes;
    - access to the child health information system;
    - smoking cessation;
    - alcohol misuse;
    - maternity - vulnerable & disadvantaged families; and
    - access to mental health services during and after transition.

151. It is recognised that military personnel put themselves in harm's way in the service of their country, risking risk injury or death in the course of their duty. Successive governments have recognised the debt society owes to its Armed Forces, their families and veterans, and most recently Society's obligations were recently set out in the *Armed Forces Covenant*, a framework for the duty of care Britain owes its armed forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare. They will also receive bespoke services in some agreed areas for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation.

SECTION 8: SUMMARY OF NHS ENGLAND (KENT AND MEDWAY) FINANCIAL POSITION

152. The following tables provide a summary of the projected financial position for 2014/15 and 2015/16:

Kent & Medway Summary Financial Position

2014/15				
	Allocation £'000	**Expenditure £'000**	**Variance £'000**	**Target Surplus £'000**
Primary Care	354,873	348,035	-6,838	-3,549
Secondary Dental	18,220	21,576	3,356	-182
Public Health	51,523	53,966	2,443	0
Health & Justice	49,111	47,079	-2,032	-491
Total Kent & Medway	**473,727**	**470,655**	**-3,072**	**-4,222**

2015/16				
	Allocation £'000	**Expenditure £'000**	**Variance £'000**	**Target Surplus £'000**
Primary Care	366,726	350,985	-15,742	-3,667
Secondary Dental	17,524	21,550	4,026	-175
Public Health	48,871	55,003	6,132	0
Health & Justice	51,370	48,729	-2,642	-514
Total Kent & Medway	**484,492**	**476,267**	**-8,226**	**-4,356**

154. The plans for the different direct commissioning areas had certain financial targets to meet, and the initial targets, are shown above. However, over time, and in response to the emerging national position, these have been moderated, such that collectively primary care, secondary dental and public health are now required to show breakeven plus £1.040m savings arising from the DDRB pay award. Health & Justice was required to show improvement upon the 2013/14 outturn to produce a £2.0m surplus.

155. NHS England (Kent and Medway) has used the outputs of the issued finance planning templates to drive the financial position shown above, and this plan is

consistent with those finance templates. The position above is therefore potentially impacted by the issues that are now described in this section.

Allocations

156. NHS England has issued allocations to NHS England (Kent and Medway) for each service but the source and content of each does vary. Whilst most use the allocation as at September 2013, that for public health is based on April 2013.

157. The allocations are adjusted for recurrent transfers made since September 2013 and growth has been added in all except public health, although funding for health visitors and meningitis C (four month dose) has been provided. . The allocations are adjusted for recurrent transfers made since September 2013, and growth has been added in all except Public Health, although funding for Health Visitors and Meningitis C has been provided.

158. Allocations for 2015/16 have also been issued. Those for primary care and secondary dental show a 2% uplift, whilst that for health and justice shows a 0.5% uplift and public health is the same as for 2014/15.

159. The difference in approach and content leads to different impacts on the financial position for each service.

Balances brought forward

160. The financial templates automatically adjust for balances brought forward. All surpluses and deficits generated in 2014/15 onwards are automatically carried forward, and, particularly in the case of deficits, unless the deficits are corrected either by reduced expenditure or allocation adjustments (whichever is most appropriate), there is a multiplier effect in subsequent years.

161. However, there is inconsistent treatment of carried forward balances in 2013/14. Surpluses generated in primary care are carried forward, but those in health and justice and public health are not; deficits generated in secondary dental are carried forward.

Outstanding allocation Issues

162. There are a number of service developments and changes which have not been matched by allocation adjustments:

- In 2013/14, CCGs received a central deduction to their allocations for drugs prescribed for services commissioned by local authorities and NHS England. However, the Area Team did not receive the allocation to pay for these drugs. An allocation was received late in 2013/14 to offset these costs. The net additional allocation required is £ 2.9 million.

- The responsibility for some health and justice services is expected to transfer from the Home Office to NHS England, mostly relating to Immigration Removal Centres. The costs of the services have been included in plans as a risk, but no allocation transfer has been assumed. The cost in 2014/15 is £0.4 million.

Cost pressure to be funded from central reserves

163. There has been an increase in public health allocations for the increase in health visitors employed and the Family Nurse Partnership (FNP) programme. However, as yet there is no increase for meningitis C (University), HPV vaccine and childhood influenza. Some funding, for example for bowel screening and FNP, appears to be less than is required to fund the increased level of service, and the balance is shown as a risk.

Section 7a public health agreement

164. The realignment of public health costs between public health and primary care has meant that £5.4 million of costs and allocation are shown under primary care in 2014/15, whereas they were included under public health in 2013/14.

Expenditure

165. The plans have been drafted assuming that the expenditure outturn for each year will be the total sum spent for that service. As such, this drives a current position which includes all significant risks.

166. NHS England (Kent and Medway) has made a number of assumptions regarding cost pressures impacting on 2014/15 spend. These will be reviewed with the aim of achieving consistency with other area teams in the NHS South area where necessary.

167. The plan reflects the savings which have been identified to date. Work will continue in-year to identify further opportunities, for example, by taking account of wider bench-marking across NHS England.

168. NHS England (Kent and Medway) is expected to identify 2.5% non-recurrent expenditure ("Headroom"). Given the challenges apparent in the current financial planning templates, the area team is currently applying this resource to the reported expenditure and is not expecting to declare unapplied Headroom.

SECTION 9: SUMMARY OF KEY RISKS

169. There are a number of risks and assumptions that are inherent within this plan. These are outlined in this section and are under ongoing review.

170. The following table highlights the key risks that are inherent in this document:

Area	Risk	Mitigation
Corporate	Management capacity is constrained and further financial savings needs to be delivered in 2014/15 and 2015/16. This constraint may limit the ability to deliver this plan.	Plans are being developed to deliver required efficiencies and ensure core functions can be maintained.
Corporate	Further development of the complaints function is critical to ensure that "hidden" complaints are formalised and used to inform a complete picture of provider performance.	Local plans to further develop the complaints function to be identified and presented to QSG
Clinical advice	The availability of clinical advisors presents a risk to a number of core activities. This includes determining the employment model for clinical advisors and ensuring appropriate indemnities are in place.	Discussions taking place with national policy colleagues on how to ensure clinical advisor capacity is in place
Commissioning Support	Business intelligence support has been put in place but arrangements are still immature and a number of data accuracy issues have been identified (e.g. public health trajectories, secondary care dental, secondary care health and justice services). These impact on the ability to robustly commission and monitor delivery.	Work taking place to further develop business intelligence support.
Public health	Significant financial pressures remain in the public health budget and these have the potential to disrupt service provision and the delivery of the performance trajectories outlined in the above table. The planned performance detailed in this document is subject to the financial pressures being resolved.	Ongoing work is taking place with regional and national colleagues to address allocation issues. Work is also taking place to review this within the mandate of 7a agreement.
Commissioning Support	NHS England has only had limited access to information governance support, which has presented risks around information governance compliance.	A service level agreement has been established with Kent and Medway Commissioning Support
Health and justice commissioning	The development of the Kent and Medway Sexual Assault Centre has been priotised in 2013/14 following the previous service coming to an end. However, work now needs to focus on	Interim protocols are now in place and joint working group in place to determine the

	putting in place robust arrangements for paediatric victims of sexual assault and abuse.	commissioning pathway
Health and Justice	Cancelled secondary care appointments impacting on access to secondary care due to prison staff not being available to escort patients or undertake bed watches	Under discussion locally and nationally with a view to putting in place agreements between agencies / organisations to improve performance
Primary care	Lack of capacity and capability in primary care services to support a shift from secondary to primary care (including a range of workforce issues such as recruitment and skill-mix)	To be addressed in 5 year plans
Primary care	The GP IT capital allocation will not cover the required capital refresh (especially noting that Microsoft will stop supporting Windows XP and a large volume of computers are using this operating system).	Development of a robust IT strategy for primary care that both enables the benefits of technology to be exploited whilst managing a difficult financial position.
Primary care	Limited scope for efficiency saving, partly due to the predominance of GMS contract in Kent and Medway (85%) and as PMS reviews have already been undertaken.	Other savings opportunities identified but these largely relate to ensuring robust contract management.
Primary care	Sustainability of general practice is at risk in some areas as we anticipate a number of practice closures over the next 2-5 year period as a result of decreasing margins, increased regulation, ageing workforce and difficulty in recruiting new GPs.	To be addressed in 5 year plans
Primary care	Patient experience has been decreasing year-on-year while expectations have increased. Improving patient experience is likely to require some significant changes to be made in some areas. This means improvements in patient experience are unlikely to be seen immediately in all services.	To be addressed in 5 year plan.
Primary care	Primary care support (PCS) services (provided by Kent Primary Care Agency) are subject to a significant change programme, dependent on approval of plans by the NHS England Board. This introduces business continuity risks (e.g. in relation to payments, management of patient note, etc...)	Mitigations being established through the PCS programme

Secondary care dental	Current secondary care dental contracts are over-performing and the ability to address this is partly constrained by poor business intelligence and partly by the ability to invest in community dental services.	Plans to be developed.

171. The risks in this plan will be reviewed and migrated to the NHS England (Kent and Medway)'s risk register to ensure they are robustly managed on an ongoing basis.

SECTION 10: SUMMARY

172. This paper details the commissioning plans of NHS England (Kent and Medway). Comments from stakeholders and partners are welcomed.

173. It is important that this plan is not read in isolation and should be read in conjunction with:

- Kent and Medway CCG two year operational plans
- The NHS England (Kent and Medway) strategic framework for primary care
- The Kent Annual Public Health Report
- The Medway Annual Public Health Report
- The Kent Joint Strategic Needs Assessment
- The Medway Joint Strategic Needs Assessment
- The Kent Health and Wellbeing Plan
- The Medway Health and Wellbeing Plan

174. These plans will continue to be refined and in particular there will be a focus on working with the three local planning footprints (e.g. the East Kent CCG Federation, the North Kent CCG Alliance and West Kent CCG) to develop five year strategic plans for submission in June 2014.

175. For Health and justice healthcare commissioning and public health commissioning the strategic direction will largely be determined through national work programmes. Local plans will be shaped around these national documents but local strategic focus in the five year plans prepared with CCGs are likely to focus on:

a. addressing any ongoing service performance issues;

b. through the gateway services for prisoners being released from prison back into the community; and

c. secondary care services for the health and justice population.

176. The strategic development of primary care is also being considered at a national level, building on the engagement that has taken place through the Call to Action, and further information on the strategic development of primary care services will be released during 2014/15. However, the development of local plans is also necessary and NHS England (Kent and Medway) has produced a strategic framework for the development of primary care. This will now be built upon to support the development of local strategic plans.

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN

NHS England

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities

- Promote a healthy start in life through universal delivery of the national Healthy Child Programme from pregnancy to - 5 years , including Health Visiting and Family Nurse Partnership and robust Ante Natal Newborn (ANNB) screening
- Deliver national Immunisation Programmes and improve uptake to increase herd immunity and reduce the risk of infectious outbreaks
- Deliver the National Cancer Screening Programmes to help improve early diagnosis of breast, bowel and cervical cancer
- Deliver the non-cancer screening programmes (e.g. diabetic eye screening, abdominal aortic aneurism (AAA) screening.
- Improve support to victims of sexual assault , enabling timely access to care, prevention/prophylaxis treatment and recovery support.
- Working with Health and Justice Teams to improve access to public health programmes in the prison population

Strategic Context and Challenges

- Using improved data sets Identify variation in immunisation and screening coverage
- Review all provider contracts benchmarking against national services specifications and strengthening contract and performance monitoring systems
- Ensure safe transition of universal healthy child programme to Local Authorities commissioning
- Implementation of new programmes and work with partners to take account of pace of change across wider systems
- Improving uptake of section 7a commissioned services for marginalised and at-risk groups.
-

QIPP Improvements

- Introduce relevant CQIN targets to new contracts
- Reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease.
- Identify risk of disease and disability early by commissioning of safe and effective screening programmes
- Work with providers to demonstrate the value of the *universal* Healthy Child Programme
- Ensure commissioned services represent best value for money and are evidence based
- Benchmarking the payment and contracting mechanisms of our commissioned services to ensure and equity of provision.
- Reprocurement of schools based immunisation team

Organisational Development

- Continued work with the PHE embedded Screening and Immunisation team to maximise skills , expertise and resources, define roles, accountabilities to deliver the work programme
- Develop and implement a programme management approach to the public health commissioning programme to ensure an integrated approach to the programme
- Build collaboration across wider other Area Team commissioning and contracting teams (Primary Care, Specialised Commissioning, Armed Forces, & Health and Justice) in order to maximise resources, nursing and quality directorates and operational delivery.
- To continue to develop relationships with CCG and local authority commissioners and providers in the local health economy
- To provide training and development opportunities to the Public Health team to develop skills and improve team resilience
- The continuation of the partnership approach developed with the local authority and Health & Well-being boards.

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN

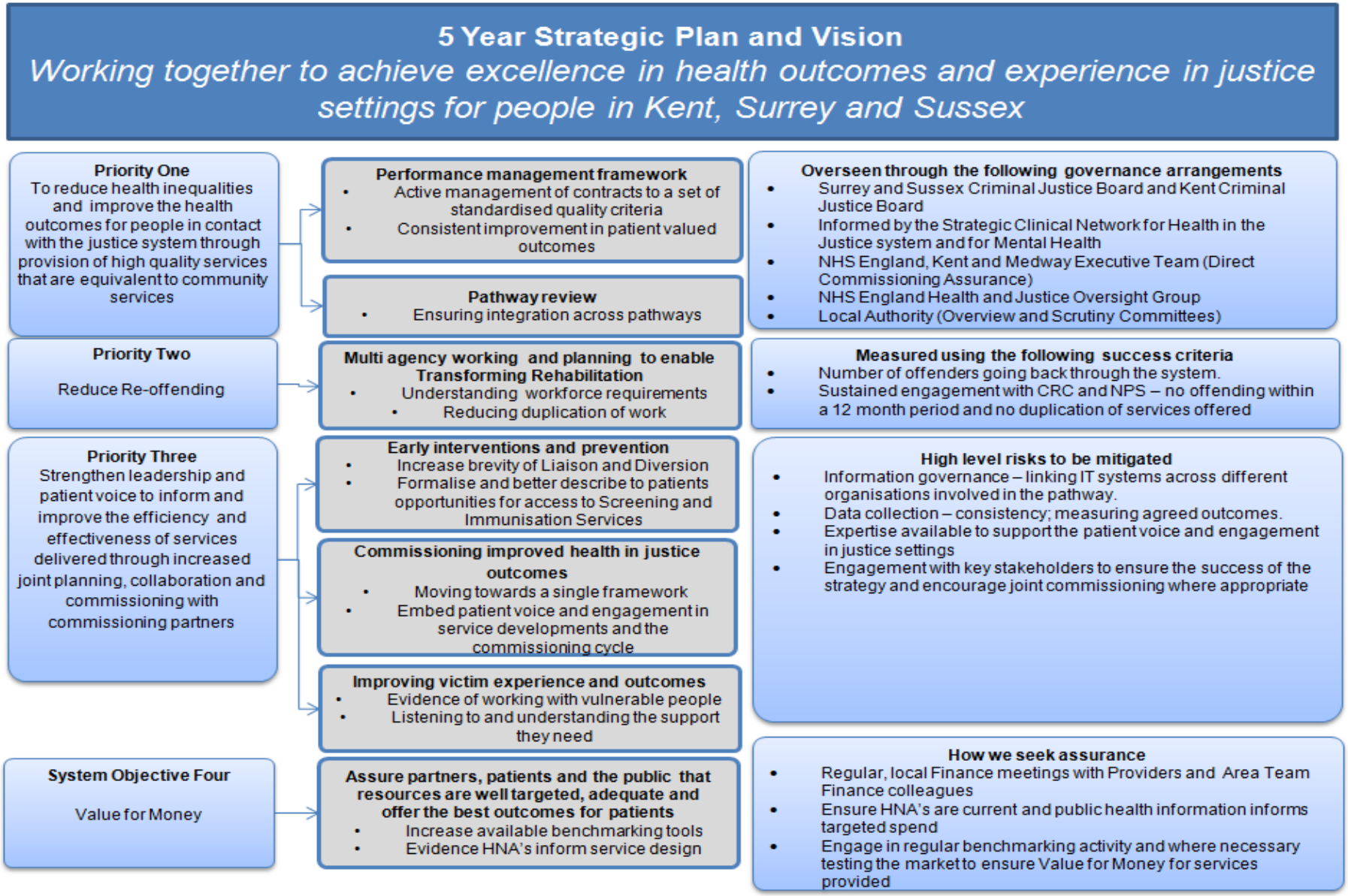
	National Priorities 2014-15	Expected Outcomes of Implementing National Guidance locally in 2014-15	End State Ambition 2015-16	Additional Local Priorities 2014-2018
Immunisation	• Seasonal Flu Programme for children is to be further rolled out to include 4 years olds with piloted programme for year 7 children. • Embed the Men C adolescent booster programme in school immunisation programme • Commission the extension of Men C immunisation for University entrants, • Continuation of MMR catch up, Pertussis in pregnant women, Shingles in 70/79 year olds • Continued improvement of flu vaccinations in healthcare workers, at risk children, pregnant women and at risk over 65s' • Implement pneumococcal vaccination specification	• Increased participation in the flu vaccination programme, reduction in avoidable hospital admissions and severe complications in at-risk patients. • Improved immunisation uptake particularly for at risk and marginalised groups. • Increased herd immunity and reduction in improvements in public health as a result of the extension of the childhood flu programme	• High uptake levels and reduction in variation in up-take • Reduction in vaccine avoidable disease. • Improved timely data available at GP practice level with national benchmarking and trend analysis • Systems in place for fully auditable immunisation payment mechanism in primary care	• Alignment of health visiting programme to support improved childhood immunisation up-take • Evaluate performance and set local improvement targets for new and existing programmes • Review and revise all local contracts and contracting mechanisms to improve performance • Access the school-age immunisation provision against capacity and other competing targets • Implement CQRS as a mechanism for data collection and payments for primary care

Screening Programmes (Non-Cancer)	• Review existing services to identify areas of non-compliance to national specifications and risks to programme delivery. Develop action plans to ensure full delivery to national specifications by March 2015 • Introduction of the new performance baselines for Diabetic Eye Screening • Implementation of the DNA test as part of the Sickle Cell and Thalassemia Screening Programme • Ensure that the payment for the antenatal and new-born screening and immunisation programmes are recognised within the Maternity Pathway Payment and that there is not a subsequent reduction in activity or quality. • Changes to QOF points in relation to diabetic eye screening	• Increased participation in screening programmes with reduced variation between local populations • Review of the participation in antenatal and new born screening services, analysis of the root causes of variation and the spreading of identified best practice • Benefits across of early detection and diagnosis of disease and disability.	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and early detection of disability, and an overall more positive experience from the health service • Full participation in screening programmes to support goal of giving every child a healthy start in life	• Continue to develop governance process for assuring improvements in non-cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary • Benchmark programmes across the region with a view to standardise payments and improve VFM

Screening Programmes (Cancer)	• Review existing services to identify areas of non-compliance against national specifications and risks to programme delivery (to ensure compliance by March 2015). • Age extension for existing Bowel Screening Programme (men and women 75 years) • Introduction of HPV testing as part of the Cervical Cancer Screening Programme for women with mild / border line changes • Age extension for breast screening (randomisation by GP practice) all women who 70-73 or 47-50.	• Full rollout of age extension bowel and breast screening programme with sustained timely access to diagnostics and subsequent treatment • Increased participation in screening programmes with reduced variation between local populations • Benefits across the health system of early detection and diagnosis of cancer	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and an overall more positive experience from the health service	• Continue to develop process for assuring improvements in cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary • Re-commission the cervical screening programme for armed forces personnel to represent a fair and equitable programme across the system.
NHS England and PHE agreements	• Develop common strategies to improve outcomes • Continue to strive for improved and timelier data collection and better commissioned 7a services.	• Close partnership working with coordinated and integrated commissioning intentions	• Full utilisation of Public Health Advice Service by public to measurably improve domain outcomes	• Continue to develop governance arrangements • Ensure local prison services have appropriate access to public health services

0-5 years Programme (including HV and FNP and Child Health Information System)	• Implement the 14/15 workforce trajectory for Health Visiting Call to Action, and continue to review and report performance on a monthly basis. • Continue to collect and monitor the quarterly data in relation to Healthy Child Programme Outcomes • To plan and work towards the transition of the Healthy Child Programme (0-5) to local authority. Transition Boards/Groups will provide regular updates to all stakeholders • Implement the new trajectory for Family Nurse Partnership expansion	• Increase in Health Visiting workforce and resultant improvements in service delivery • Expansion of Family Nurse Partnership to improve outcomes for young vulnerable first time mothers and their families. • Healthy child programme (0-5 year olds) transition to local authorities with commitment to sustain programme	• In October 2015, commissioning responsibility for this aspect will transfer to Local Authorities (the aim is for the expected service capacity and all national standards to be sustainably delivered prior to transfer).	• Ensure safeguarding and quality arrangements in place reported through Quality Surveillance • Commissioning and implementation of existing and planned new Family Nurse Partnership Programmes.

ATTACHMENT 2: HEALTH AND JUSTICE SUMMARY PLAN



ATTACHMENT 3: PRIMARY CARE SUMMARY PLAN

NHS England

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment

Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Primary care: current landscape

1. *Variation in quality and performance*
2. *Some patients have difficulty accessing primary care services*
3. *Some patients struggle to navigate the health care system*
4. *Patients using hospital services inappropriately*
5. *Significant number of premises fail to meet required standards*
6. *Significant number of small practices managed by sole practitioner contractors*
7. *Uneven distribution of resources between practices and across CCGs*
8. *Community pharmacy plays limited role*

General practice in Kent & Medway: current landscape

1. *Registered population of circa 1.4 million*
2. *8 CCGs, covering populations ranging from circa 106,000 to 460,000*
3. *262 GP contractors, 34 PMS 13, APMS. 85% of practices are GMS – unusually high and limits scope of local QIPP*
4. *3 GP-led health centres . Their future is the subject of review by CCGs and the local area team*
5. *Some practice premises do not meet minimum standards*
6. *There are significant GP recruitment issues in parts of Kent and Medway.*

Primary care: future landscape

1. *Consistent levels of high quality performance*
2. *Robust patient and public engagement informing commissioning*
3. *Comprehensive range of services provided in primary care settings including a wide range of diagnostic tests and treatments*
4. *Services are available at times and places that are convenient to patients and appropriate to need*
5. *The highest risk patients identified and patient-focussed pathways put in place*
6. *Premises of consistent quality and meeting minimum standards*
7. *Sustainable provider landscape with services delivered at-scale*

Key challenges

- *Large geographical footprint with many contractors.*
- *Legacy of predecessor organisations and the history and relationships forged with contractor groups*
- *Nationally negotiated contracts leave limited scope for savings.*
- *Large number of small practices*
- *Significant number of elderly sole practitioner contractors.*

Improvements

- *Driving up quality by reducing variation and tackling unacceptable levels of service*
- *Improved access to GP services*
- *Wider range of services provided in community pharmacy and general; practice*
- *Increases in flu vaccination coverage*
- *Improvement in the prevalence of depression compared to estimated model*
- *Post payment verification and audit activities*
- *Review of discretionary payments*

ATTACHMENT 3: PRIMARY CARE SUMMARY PLAN

	Priority objectives	Key Area Team outputs in: 2014-16	End State Ambition 2019-20
1.	QIPP	• PMS reviews • Procurement of APMS contracts that will come to an end • Tackling list inflation • Probity program • Review of minor surgery and anti-coag' DES/LES schemes • Ensuring all practices are being charged appropriately for occupation of NHS PS premises • Dispensing patient review	• Reduced variation in spend on primary care across CCG areas and between GP practices • Unacceptable levels of PMS premiums removed • More consistent set of commercial terms across APMS contract
2.	Drive continuous quality improvement	• Quality of care can be measured and benchmarked • Definition of what good looks like agreed with public, CCGs and other key stakeholders • A continuous quality improvement strategy & delivery plan overseen by ATs Primary Care Quality Hub • Agree a consistent, rigorous and risk-based approach to monitoring quality through practice inspections and deep dive reviews • Maintain and further develop Local Professional Networks (LPNs) and produce work plans and support delivery of key strategic objectives	• Reduced level of variation • Numerous examples of where unacceptable levels of quality have been addressed successfully • CCG facilitated learning networks supporting peer-to-peer challenge and learning • LPNs leading strategic change and improvement

3.	Developing infrastructure and reconfiguring primary care	• Address short-term pressures in workforce • Promote improvements in primary care premises by completing a stocktake of general practice premises and developing an strategy for premises/estates in conjunction with patients, public and other key stakeholders • Improve use of IT systems to improve primary care in collaboration with CCGs • Review of Minor Surgery DES/Les service specification • Review of anti-coagulation LES and use of PGD/development of pharmacy prescribers • Roll out EPS in general practice • On-line booking, access to medical records on-line, order repeat prescriptions on-line	• General practice delivered from fewer premises and reduced number of practices operating from premises that do not meet minimum standards • Much wider range of services delivered in community pharmacy and general practice
4.	Improving access and services	• Methods for engaging patients and the public in contracting changes and procurements enacted by the Area Team • PMS review to be completed in collaboration with CCGs • Procurements for a number of existing APMS contracts, OH services, interpreting services and clinical waste. • Piloting innovation e.g.: 8am – 8pm working, 7 days per week, e-consultations • Ways of enabling registration at GP practice of choice are introduced	• QSGs are successfully identifying and addressing quality issues in a whole systems, collaborative and supportive manner • A robust system for managing contracts and performers whose performance gives rise to concern is well established • Methods for patient and public engagement in contracting changes and procurements are robust and well established • PMS & APMS contracts reflect strategic direction • Improved choice, and access to and satisfaction with general practice

5.	Perform assurance role	• Maintaining up-to-date contract documentation • Annual GP practice reports received and reviewed • Work closely with CQC in responding to evidence of poor quality • QoF assurance program • Self-funded probity function established and program agreed • Effective management of counter fraud activity • Review contractors' business continuity arrangements and ensure that these are robust at both individual service and whole system levels	• Robust and effective counter-fraud mechanisms well established • Targeted QoF visits and self funded probity program • All contractors have clear and up-to-date business continuity arrangements

ATTACHMENT 4: SPECIALISED COMMISSIONING SUMMARY PLAN

NHS England

Values and Principles	Services are patient centred and outcome based	Improved outcomes delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves
Domains	Prevent premature death	Quality of life for patients with Long Term Conditions	Help recover from ill health / injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 13/14	Strategic Context and Challenges	QIPP Improvements	Organisational Development
• Implementation of national service specifications • Resolution of derogation programme with a focus on commissioner led derogations • Provision and modernisation of radiotherapy capacity to improve access for patients and to improve outcomes for patients • Continuing review of vascular services to ensure compliance with national standards • Compliant rare cancer services, e.g. specialised urology • Delivery of compliant major trauma centre in Sussex in regard to neurosurgery • Implementation of recommendations from Winterbourne Review	• Review the implications at a local level of the financial challenge of operating within a deficit budget • Support national review of single operating model for specialised services ensuring local effective engagement • Engage proactively with the Call To Action strategic planning, being clear on local implications • Supporting good access to mainstream specialised services for Kent, Surrey and Sussex patients • Continue to strive for effective relationships with key partners, Patient and Public, Clinical Reference Groups, CCGs, other Area Teams, Health & Wellbeing Boards, HOSCs, providers, Strategic Clinical Networks, ODNs, PHE and clinical senate	• Review and adoption of national and local QIPP/Productivity and Efficiency schemes to meet the challenge of 9% over 2 years front loaded in 14-15 • Input into national process for procurement of high cost drugs and devices • Implementation of nationally agreed clinical access policies • Support clinical and patient engagement with the innovation, health and wealth ambition	• Continue to develop contract management skills and expertise within the team • Support development of matrix working and networking of teams, across national, regional and local landscape • Continue to support staff to embrace NHS England vision and values • Work with SCN colleagues embedding local process to support patient and public voice through engagement and participation • Support provider engagement, in particular regard to strategy, for specialised services, contracting and data quality improvement

ATTACHMENT 4: SPECIALISED COMMISSIONING SUMMARY PLAN

	National and Local Priorities 2014-15	Expected Outcomes of Implementation in 2014-2015	End State Ambition 2015-16 and onwards to 2018-19
Internal Medicine	• Cardiac – Review of TAVI audit and implement recommendations • Review specialised cardiology provider landscape • Implementation of vascular reviews in Sussex and Surrey, commence review of Kent & Medway services	• Achievement of core clinical and quality requirements • All cardiac and vascular services to meet national service specification	• All services compliant with national standards and achieving improved outcomes for patients • Safe and sustainable services with clear patient pathways understood
Cancer and Blood	• Implementation of national recommendations for radiotherapy and increased access to IMRT and IGRT • Work with region and providers to ensure compliance with e-prescribing for chemotherapy • Ensure compliance to national specifications of specialised cancer services • Cancer Drugs Fund – support Wessex with implementing national process and policies • HIV/AIDs - review provider landscape following sexual health reviews working with Public Health and Local Authorities	• Implementation of locally agreed plans to improve quality and access to radiotherapy for patients • Working with Brighton & Sussex University Hospitals Trust (BSUHT) to review provision of radiotherapy and integrated chemotherapy service at Western Sussex Hospital's Trust • E-prescribing operating effectively across all providers as relevant • To be clear on HIV/AIDs treatment and care pathways supported by adequate resources	• Improved access to radiotherapy • Consistent national tariffs in place • Patients to receive optimum care • Consistent and equitable provision of chemotherapy and cancer drugs • High quality HIV/AIDs services in place

Trauma	• Support Major Trauma Centre (MTC) at BSUHT , ensure all codependent services are meeting national service specifications through derogation as required • Work with regional lead to review the implications of the national service specification for Queen Victoria Hospital • Oversee the outputs of the Operational Delivery Networks (ODN) for adult critical care in relation to specialised services	• MTC to be fully compliant with national service specification, standards and quality requirements • London and SE consensus on the configuration of burns services • Effective ODN in place for adult critical care (specialised)	• Safe and sustainable services in place • Burn care services compliant with the national model • Effective network model of adult critical care for specialised services in place
Women and Children	• Oversee the outputs of the Operational Delivery Networks (ODN) for neonatal providers • Implementation of networks for Children's Safe and Sustainable Review (Cardiac and Neurosurgery) • Review paediatric shared care model across Kent, Surrey and Sussex, working with other ATs as relevant	• Effective Operational Delivery Network (ODN) in place for neonatal care • Neonatal services to achieve national service specifications, standards and quality requirements • Implement outputs of the paediatric cardiac surgery review • Implement prime contractor model for paediatrics as relevant	• Improved network and pathway management • Safe and sustainable services
Mental Health	• Embed secure service and CAMHS Case Management and gate keeping • Review of compliance to service specifications and clinical polices • Assess capacity in low & medium secure services	• Continued focus on these areas to manage demand • Improved quality and consistency of services • Review of identified priority areas • Local assessment of capacity • Provision of high quality, clinically safe services	• Case management in place for all specialised MH services • Compliant services • Improved access to and egress from secure services

ATTACHMENT 5: PUBLIC HEALTH COMMISSIONING INTENTIONS

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
School based immunisations	To commission a school immunisation team for Kent and Medway to provide school based immunisation programmes. Current provision is through Medway NHS Foundation Trust (MFT) and Kent Community Health NHS Trust (KCHT) who provide a mixed model of school based immunisation programmes, i.e. via school nursing service in the east of the county and a standalone immunisation team in the west.	Review the need to decommission the current programme and procure a single school based Kent and Medway immunisation service in order to ensure consistency in delivery of vaccinations across the county.	KCHT and MFT	Costs are not identified at present. Reference costs are being sought from providers to inform service redesign.	School based immunisations are part of a block contract at present. Both providers have been extracting costs of current provision. This commissioning intention has implications for school nursing services which are currently commissioned by Medway Council and Kent County Council. An immunisation team is already in place for West Kent.
Meningitis C (MenC) immunisation programme MenC adolescent booster school year 9 - starting January 2014	Current school nursing team to be commissioned to provide MenC at 14-15 years, with GP's immunising children that did not receive vaccine via school nursing.	Commission KCHT and Medway NHS Foundation Trust (MFT) school nursing team to deliver Men C adolescent booster. Issue Local Enhanced Service for MenC to GP's for those that did not receive vaccine via school nursing.	KCHT & MFT school nursing and GPs	National guidance proposes that funding to deliver the adolescent Men C programme will be transferred from primary care where the second dose (now ceased) has been funded within GP contract/global sum.	To enable Men C to be commissioned from current providers we are currently seeking reference costs from Medway providers and will benchmark against KCHT and other areas to ensure VfM in the commission.

MenC catch up for first time university entrants under the age of 25	From mid-August 2014 there will be a catch up programme of limited duration (possibly up to 5 years) to offer the vaccine to first time university entrants under the age of 25.	Likely to be commissioned via a GP Local Enhanced Scheme (LES); further national guidance awaited	GPs - this programme will be mainly delivered through primary care.	Further information will follow relating to funding and vaccine supply arrangements for the catch-up.	Awaiting further information relating to the funding and vaccine supply.
Men C Removing 2nd 4 month dose	Childhood immunisations are classified as additional services in the GP contract and the infrastructure costs of delivering these are covered by the GP practices global sum payment or baseline PMS funding. GPs are also eligible for target payments if they have vaccinated 70% to 90% of their 2 year cohort.	Decommission 2nd MenC dose in line with national policy around clinical effectiveness	GPs (with a need to inform other providers who provide patients with advice and information)	NHS England plans an adjustment to those target payments to reflect the change from 2 doses to 1 dose, however this adjustment will not be made until 2015/16, reflecting that vaccination status is not assessed until children reach 2 years.	
Human papillomavirus (HPV) - Local Enhanced Service contract ended in August 2013. This service is for children who were not vaccinated under the school programme	Area Team to issue an HPV local enhanced scheme (LES) for general practice to reflect new commissioning arrangements for Jan 2014	Specification to be written	GPs	£9.00 per item	

HPV - School Nursing Team	School nursing team to be commissioned to provide HPV at 14-15 years (with GPs immunising children that did not receive vaccine via school nursing - see the row above).	Revised contract in year	KCHT and MFT school nursing teams		
Additional childhood flu vaccination	The national Joint Committee on Vaccination and Immunisation (JCVI) has recommended that the seasonal influenza programme be extended to all children from aged two up to the age of 17. This programme has been rolled out to all healthy two and three year olds in the 2013/14 flu season as part of a gradual step to full implementation. This programme is in addition to the existing routine seasonal influenza programme.	Service redesign and service specification. Make provision for 4 year olds. Commence delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible.	Best vaccination uptake among 5-16 year olds is likely to be achieved through a school based programme – involving school nursing teams and GPs.	Awaiting further information and funding from NHS England.	

ATTACHMENT 5: PUBLIC HEALTH COMMISSIONING INTENTIONS

Health visiting	NHS England (Kent and Medway) and Health Education England Kent, will work together to increase the number of health visitors as required by the national programme, monitored by the Department of Health. In Kent and Medway the increase in the number of health visitors is planned to be in line with the nationally agreed trajectory of 421 whole time equivalent (wte) health visitors by April 2015. This represents 342.2 wte employed within Kent Community Health NHS Trust (KCHT) and 78.8 wte for Medway Community Healthcare (MCH). This equates to an increase of 68.2 wtes for KCHT and 7.7.wte for MCH in 2014-15.	A national service specification is in place with local trajectories in term of delivery of the new model aligned to the Healthy Child Programme (HCP 0-5 years)	KCHT and Medway Community Health (Social Enterprise)	Additional costs of £1,544,190 for 2014/15.	Mandated programme in line with Department of Health
Family Nurse Partnership (FNP)	Expansion of FNP by one team in both Kent and Medway, thus increasing the number of places by 100 for each area. Kent and Medway are both on the national expansion plan and will therefore contribute to the Department of Health planned increase to 16,000 places nationally. Linked to Public Health Outcomes Framework.	Nationally driven programme aligned to the Health Visitors Programme using a sub license. There is therefore no service change, but just an increase in the number of FNP places	KCHT and MCH	Awaiting costs	Awaiting confirmation of funding

Child Health Information System (CHIS)	The current Careplus CHIS will be replaced by the new SystmOne system during 2014. This system is being deployed across the entire South of England region. This will provide an integrated IT system across Kent and Medway. Work is needed to integrate the Medway Child Health Record Department (CHRD) with the Kent team under a single management structure. This will provide: • a strengthened governance arrangements for CHRD with improved performance monitoring process; • the potential to increase opportunities for learning and development within the team; • efficiency and streamlining as a result of having one single, larger team; and • support robust project plan for implementation of SystmOne.	The service charge relates to the integration of the CHRDs in Kent and Medway.	KCHT and MFT	Full costs to be confirmed following regional and national review of associated costs of new system procurements	
Diabetic Eye Screening service re-procurement.	Continue with and complete the diabetic eye screening re-procurement. The service is being reprocured as the existing contract for the local diabetic eye screening service is nearing the end of its period of operation and under procurement rules, NHS England's Kent and Medway Team is required to re-tender. The objective is to ensure that appropriate services are in place to support the prompt identification and effective treatment of sight threatening diabetic retinopathy. The priorities are to: - ensure effective contract transition processes are in place;	Re-commissioning	Pending outcome of tendering process	Costs to be confirmed subject to the procurement	The new contract is due to be let at the end of May 2014.

	- identify transition risks and ensure mitigating actions are implemented; - ensure services are delivered in line with national service specifications; and - any gaps in service provision are addressed in order				

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Paediatric Sexual Assault Referral Service (SARC) Kent, Surrey and Sussex	To commission fit for purpose Paediatric SARC Services in Kent and Sussex and seek reassure of quality of care pathway and service in Surrey by April 2015	The key stages of the work are service design, development of an options paper, consultation and procurement of Paediatric SARC services	Services delivered on a cost per case basis, anticipate there will be a limited impact on current providers due to low volume	Funding has been identified for the health element of the paediatric SARC from budget uplift received	National funding arrangements, roles and responsibilities across Partners to be clarified
Sussex Sexual Assault referral Centre (SARC)	Re-procure Sussex SARC Phase 1 (health element) by June 2014, Part 2 (social care element) by April 2015	Re procure service	Tascor	Sussex Police and local authorities transfer their budgets to NHS England	Further development of Forensic Medical Examiner (FME) service necessary
Kent Sexual Assault Referral Centre (SARC)	Re procure Kent SARC Forensic Medical Examiner (FME) and Forensic Nurse Practitioner (FNP) element by June 2014 and deliver FME and FNP training programmes . Extend service to be able to receive self-referrals by Autumn 2014.	Re procure FME / FNP element Review Kent SARC care pathway	FMEs paid on a retainer, no contracts in place	Kent Police confirmed financial envelope available, NHS England anticipating contributing to uplift	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.
Kent Sexual Assault Referral Centre (SARC)	Agree development plan for the new Kent and Medway SARC, including the move to self-referral January 2015	Review service specification and review care pathway	Kent and Medway Partnership Trust, Family Matters, East Kent Rape Line and Kent Police	Uplift received will ease any cost pressures that the review and further development of an excellent Kent SARC may require.	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Surrey Police Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (Kent and Medway) for 1st April 2015	Transfer of commissioning responsibility anticipate novation of contract to NHSE	Tascor	None known	Preparing Statement of Readiness
Kent Police Custody Healthcare Commissioning Transfer	Re procure FME provision into Kent and Medway police custody suites and prepare for transfer of commissioning responsibility of FNP service to NHS England (Kent and Medway) for 1st April 2015	Implement a re procured FME service into police custody by Summer 2014	FMEs paid on a retainer, no contracts in place	None known	Market testing underway
Sussex Police Custody Healthcare Commissioning Transfer	Support Sussex Police to uncouple FME and FNP element of block custody contrac by July 2014	Activity on-going to extrapolate health element of contract in order to re-procure	Tascor	None known	Preparing Statement of Readiness
Surrey Prisons - Virgin Healthcare	Review and redraft service specifications, key performance indicators (KPIs) and service delivery improvement plans (SDIPs) for healthcare provision for each of the four Surrey prisons. Incorporating a formal review of in-patient services at HMP Highdown by June 2014	Service specification, KPI's , Quality Dashboard and SDIP	Virgin	None anticipated	NHS England (Kent and Medway) working to embed partnership working with the provider
Surrey Prisons - Surrey and Borders NHS Foundation Trust	Review and redesign of mental health Service and contractual supporting documents September 2014	Service specification, KPI's , Quality Dashboard and SDIP	Surrey and Borders Partnership Foundation Trust	Commissioner may seek uplift in funding if identified as necessary for a comprehensive mental health service i.e. improving access to psychological therapies (IAPT) service	Provider aiming to being a Phased implementation from 1st April 2014
Surrey Prisons - Virgin Healthcare	Re procure clinical and psycho-social elements of substance misuse services across Surrey Prisons fro implementation by 1st May 2014.	Re procurement completed, contract awarded and announced	Virgin	A saving of no more than 3100,000.00 per annum is anticipated	Contract transition and mobilisation planning underway.

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Review of Discipline Officers enabling healthcare functions across all Kent, Surrey and Sussex prisons	Review the role and function of Discipline Officers who enable healthcare functions across all Kent, Surrey and Sussex prisons and plan with Governors for the transfer of funding responsibility from 1st April 2014	Novate commissioning responsibility from NHS England to Prison Service	Prison Service / National Offender Management Services (NOMS)	Cost pressure for NOMS, release of funds for NHS England to reinvest in clinical services	National programme of work but adopting a local delivery plan
HM Prison Lewes and Ford health services re procurement	Re procurement of healthcare services for 1st April 2015	Re procurement	Sussex Partnership NHS Foundation Trust	Unknown until procurement complete	Current Provider and NOMS advised of intention.
HM Prison/ Young Offenders' Institute (YOI) Rochester and HMYOI Cookham Wood reprocurement	Re-procurement of primary healthcare, pharmacy and child and adolescent mental health services (CAMHS) (Cookham only) for 1st April 2014	Re procurement	Prison Service	Anticipated this will be cost neutral	New ways of working fully implemented at Rochester, Cookham operational capacity increase and Rochester re-roll to 70% adults. Procurement completed and contract awarded and announced.
Telemedicine	Develop a business case and feasibility test regarding the introduction of telemedicine in the Kent, Surrey and Sussex prison estate. Report expected Autumn 2014.	Service innovation	Miscellaneous	Anticipate it will be cost neutral	NHS England (Kent and Medway) need to progress development work with key stakeholders
HM Prison Bronzefield - primary healthcare and psycho-social substance misuse services	Close partnership working with NOMS to support the prison to review its existing service specifications and associated contract document suite i.e. key performance indicators (KPIs), service deliver improvement plans (SDIP), quality dashboard, adopt serious incident reporting framework, complaints process and Prison Health Performance and Quality Indicators (PHPQI) framework	Review and refresh of Service specs, KPIs, SDIP, Quality Dashboard, intro of use of PHPQI's, serious incident reporting framework, NHS complaints process	Sodexo	None	NOMS retain the budget, commissioning and contract management responsibility for the delivery of primary healthcare and psycho-social services at HMP Bronzefield. NHS England is working to support Sodexo and NOMS to prepare to transfer commissioning responsibility to the NHS when negotiations with

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

					Sodexo regarding uncoupling of healthcare element of main budget is completed.
Mental health services across Kent and Medway prison estate	Re-procurement of mental health services across all Kent, Surrey and Sussex adult prisons for 1st July 2014	Re procurement	Oxleas	Anticipated this will be cost neutral	Re-procurement well advanced
Gatwick Immigration and Removal sites (3 sites)	Transfer commissioning responsibility from UK Border Forces (UKBF) to NHS England and re procure health services by Sept 2014	Transfer commissioning responsibility and re procure	G4S	Anticipate will be cost neutral for NHS England	NHS England's London Area Team are taking the lead on a multi-site procurement, Kent and Medway actively supporting
Secure Children's Homes (SCH) – welfare only	Formalise East Sussex and West Sussex local authorities retaining commissioning responsibility for SCH whilst NHS England (Kent and Medway) take accountability through a formal memorandum of understanding (MOU). Contractually implement service uplift September 2014	Service uplift due to increase in residents and in response to refreshed health needs assessment (HNA). Area Team commissioners to confirm budget transfer value for commissioning transfer to Area Team from 1st April 2014.	Local authorities and local healthcare providers to SCH in East and West Sussex	Increase in available resources for comprehensive health services. NHS England (Kent and Medway) may need to incorporate local authority commissioning service costs into service baseline (if required by local authorities).	Local authority commissioners keen and content to carry on their local commissioning function of these bespoke placements and services for individualised packages of care

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Medway Secure Training Centre (STC)	Provide on-going support in preparation for transfer of commissioning responsibility to NHS England from 1st April 2015 anticipating a re procurement of health services by 1st April 2015	Re procurement by April 2015, transfer of commissioning responsibility December 2014	G4S	Anticipate no cost pressures to NHS England	Position regarding transfer of commissioning responsibility to NHS England still fluid as is reprocurement timetable
Surrey Police Court Liaison and Diversion Service (PCLDS)	Commission Phase 2 of Surrey PCLDS to include some court coverage and enhance existing police custody coverage April 2014	Commission	Surrey and Borders Partnership NHS Foundation Trust	Planned for service uplift	Surrey is the last PCLDS to become established across Kent, Surrey and Sussex

ATTACHMENT 7: ARMED FORCES HEALTH AMBITIONS

NHS Outcomes Framework	Outcome Ambition for AF Health	How Outcome will be monitored
Domain 1 Prevent people from dying prematurely, with an increase in life expectancy for all sections of society	**Outcome ambition 1** Mortality of the armed forces population is currently split (roughly equally) between operational causalities, accidents and other illnesses. Therefore only a very small percentages are within the powers of NHS England to affect – but we will seek additional years of life for these. We will work with the MoD to increase screening and immunisation coverage	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify Potential Years of Life Lost (PYLL) data to look at PYLL rates: • From causes considered amenable to healthcare (adult and children) • The rate per 100k population
Domain 2 People with LTCs, including those with mental illnesses get the best possible quality of life	**Outcome ambition 2** There are very few in the armed forces population who have LTCs as this will normally preclude military service. Any measures are likely to be statically meaningless Mental Health conditions are managed by DMS for serving personnel however, we will look to reduce the impact of transition from service life to civilian life and avoid discontinuity of care issues	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify average health status (EQ5D) score for individuals who identify themselves having a LTC Easy & rapid access to appropriate mental health services

ATTACHMENT 7: ARMED FORCES HEALTH AMBITIONS

NHS Outcome Framework	Outcome Ambition for AF Health	How Outcome will be monitored
Domain 3 Ensure patients are able to recover quickly and successfully from episodes of ill health or following an injury	**Outcome ambition 3** Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, in for example Regional Rehabilitation Units (RRUs)	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify emergency admissions for acute conditions that should not usually require hospital admission
	Outcome ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	NHS England will work with the MoD to develop as alternative measure around discharge of veterans
Domain 4 Ensure patients have a great experience within all of their care	**Outcome ambition 5** Increasing the proportion of people with physical and mental health conditions having a positive experience of hospital care	Armed Forces health team will work with Nursing Directorate and P&I to develop measures and baseline for AF population. Seek to benchmark against CCG patients Links to 15 questions from the national inpatient survey Rate of responses of a poor experience of inpatients care 100 patients
	Outcome ambition 6 Increasing the proportion of people with physical and mental conditions having a positive experience of care outside hospital, in general practice and the community	We will work with DPHC to reduce poor patient experience of primary care (GP and OOH services) where the NHS is in a position to influence patient experience Rate of responses of a fairly poor or very poor experience across GP and OOH services per 100 patients
Domain 5 Ensure patients in our care are kept safe and protected from all avoidable harm	**Outcome ambition 7** Working with co-commissioners in making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	NB: small dispersed population which may make information and trends statistically not significant. Monitored through SI reports

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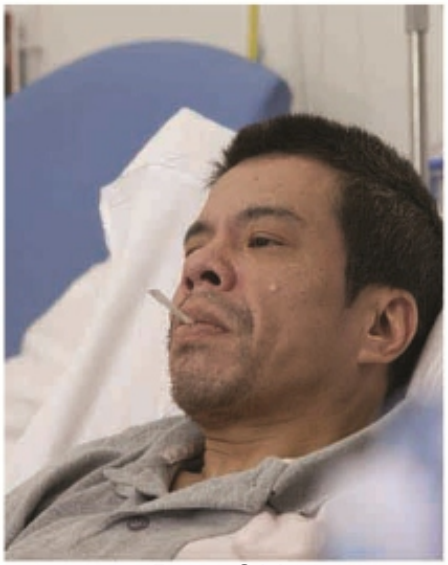
NHS England (Kent and Medway)

Direct Commissioning Strategy and Two Year Operational Plan

2015/16 Addendum



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CONTENTS

SECTION 1: INTRODUCTION

INTRODUCTION

1. NHS England (Kent and Medway) prepared a Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015. This was prepared in March 2014. It was updated in July 2014 to take account of a number of changing national priorities and to update the financial agreements that had been reached. This plan remains current and should be read in conjunction with this short paper that updates the document to take account of the 2015/16 annual planning round.
2. This document consists of:
    - Updated plans on a page for the key direct commissioning areas
    - A short narrative / commissioning intentions for each area
    - An updated financial position

PUBLIC HEALTH 7A SERVICES

3. The national ambition is to improve and protect health and wellbeing for the population. Specifically, the aim is to improve not only how long we live but also how well we live and to ensure that we support the whole community to live healthily, reducing health inequalities.
4. The Public Health Direct Commissioning Team working with Public Health England, Clinical Commissioning Groups and Local Authorities will contribute to the national ambition by improving accessibility and uptake of
    - Immunisations that reduce the risk of infectious disease outbreaks targeting areas of lower uptake, working with providers to improve performance to achieve national targets by 2018/19
    - Screening programmes that help improve the early diagnosis of major disease, disabilities and death such as Cancer, Aortic Aneurism and diabetic retinopathy to improve coverage for more vulnerable, harder to reach groups to bring them in line with the rest of the population by 2019
    - Services that improve the health and life chances of children and families to ensure that we transfer robust and sustainable services delivering the nationally agreed outcomes to Local Authorities in 2015
5. A number of aims and objectives have been identified by the public health team in relation to the services they are responsible for, these include:
    - Focus on improving data quality to ensure that the reported achievement of national targets are robust (particularly immunisations)
    - Work jointly with commissioning partners including CCGs and Local Authorities to implement coherent integrated commissioning plans along care pathways.
    - Work with all providers of Section 7A services to ensure service delivery complies with standardised core national service specifications. Where service providers are not currently working to the national specifications, then

services and programmes will be benchmarked against the national service specifications and action plans jointly agreed that clearly outline any gaps in provision, service developments proposals and timescales for alignment.

- Work with partners to apply specific CQUIN schemes to incentivise service improvement for Section 7A related services, focusing on initiatives that improve access for the entire population of Kent and Medway (including those in offender institutions) to tackle inequalities. Where appropriate 'stretch' targets will be introduced to improve coverage and uptake
- Ensure that all services clearly demonstrate how they are delivering improved outcomes for patients. This will include the systematic application of national and locally agreed outcome measures and KPIs.
- Work with providers and other stakeholders to demonstrate effective patient engagement and user experience informing continuous improvement.
- Ensure that all commissioned programmes demonstrate value for money in line with QIPP, delivering high quality, evidenced based cost effective services. This will include the systematic application of robust financial and contract performance monitoring and review processes. We will prioritise work with partners to implement pathway/system wide re-design.

6. The following are appended to this plan:
   - **Attachment 1:** Public Health Summary Plan
   - **Attachment 2:** Public Health Commissioning Intentions (NHS South / National)
   - **Attachment 3:** Public Health Commissioning Intentions (Kent and Medway)
   - **Attachment 4:** Public Health Programme and Population Risks
   - **Attachment 5:** Public Health Financial Risks
7. The services included in Section 7a are national programmes with the allocations coming under the agreement from Public Health England. Screening and immunisation programmes across Kent and Medway are based and delivered on a population base. Increases or decreases in the populations receiving screening or immunisation will inevitably impact on the cost of delivering the programmes (as outlined in Attachments 4 and 5).
8. The focus for the public health team is to ensure that these national programmes are delivered according to the national specification and that they deliver good outcomes (protection from infectious disease or early diagnosis of significant disease). The purpose of the service reviews in 15/16 will be to ensure the services are not only good quality but also represent value for money.
9. The following table details the investment in Kent and Medway Section 7a programmes:

	2014/15				2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**		**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Public Health	51,523	53,966	-2,443		40,387	42,829	-2,442

10. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for primary care commissioning. These indicators and the planned performance identified in the plan remain valid.

HEALTH AND JUSTICE HEALTHCARE

11. NHS England (South East) commission healthcare services for people in criminal justice and secure welfare settings across Kent, Surrey and Sussex. Work also continues to ensure the timely and effective transition of commissioning responsibility for healthcare in Police Custody Suites by April 2016.

12. The following are appended to this plan:

    - **Attachment 6:** Summary of South East Criminal Justice Services and Settings
    - **Attachment 7:** Health and Justice Summary Plan
    - **Attachment 8:** Health and Justice Commissioning Intentions (National / NHS South)
    - **Attachment 9:** Health and Justice Commissioning Intentions (Local)

13. The implementation of the national, standard Health and Justice indicators of Performance (HJIPs) in all of our prisons has been successful. We have agreed to pilot the new draft children and young peoples HJIPs for the national team in our YOI with development of specific suites for Police custody, SARCS and IRCS just beginning.

14. Identifying and responding to issues of quality and safety for patients has been resource intensive element of this programme of work. Resulting in some necessary re procurements where new service specifications now reflect national standards and expectations, particularly in Sexual Assault Referral Centres and our local Youth Offender Institution. The successful implementation and 'bedding in' of new contracts into some settings are a priority.

15. Increasing coverage of the Police and Court Liaison and Diversion Service across Kent, Surrey and Sussex remains a priority as Surrey and Kent move into Wave 2 of the national pilot. The need to embed the patient voice and their involvement in our commissioning cycle continues to require dedicated time and planning.

16. Implementation of new IT systems for prescriptions, smart cards and the refresh of national systems (e.g. System1) are important to maintain infrastructure in our prisons, Immigration Removal Centres (IRC's) and Secure Training Centre (STC) and Secure Children's Homes (SCH's). The implementation of these new IT systems is well underway and our focus now moves to our IRC's, STC and SCH's. E-prescribing is now live in one of our prisons and we have a tight programme to roll E-prescribing out across the Kent, Surrey and Sussex prison estate.

17. Maintaining a visible presence in the settings that we commission services for has added value and provides visible leadership for our partners and helps us as commissioners gain real insight into how services are delivered and experienced by users.

18. NHS England, working with Health Education Kent and Surrey and Sussex and local Universities are developing an educational framework to support health and care staff

working within the justice sector. This aims to improve the health outcomes for people in custody by aiding improved recruitment and retention of staff through professional and service development to meet the changing needs of this population.

19. For the majority of people in prisons and other justice settings, their engagement with these services is temporary. Most will transition back to the community, although some will go back and forth. To ensure the best, most equitable health and outcomes for them, it is essential that health and justice services are not commissioned in isolation, but are seen as part of a continuum with the services these individuals would receive in their local community.

Priorities

20. The key priorities in commissioning for health and justice from 2015/16, some of which remain the same as those set out in the Everyone Counts, are:

- Improve the response to managing detained people at risk of serious harm and support the reduction of self-inflicted deaths in detention
- To support sustainable recovery from addiction to drugs and alcohol and improved mental health services.
- Promotion of continuity of care between establishments and from custody to community working closely with Community Rehabilitation Companies, national probation services, local authorities and CCGs.
- Continued close collaboration with our partners in the successful implementation of Wave 2 of the Liaison and Diversion Programme in Surrey and Kent.
- To ensure timely and effective transition of commissioning responsibility for healthcare in immigration removal centres, secure training centre and police custody suites.
- Procure effective, timely Paediatric Sexual Assault Services in Sussex and Kent that reflect the national Paediatric SARC Service Framework
- Improve the proactive detection, surveillance and management of infectious diseases, blood born viruses, outbreaks and incidents in criminal justice settings
- Continue to implement and closely monitor national standards of excellence in the delivery of healthcare services to detained Children and Young People
- Stimulating and supporting Provider development and market engagement in the provision of health and justice settings particularly in preparation for the transfer of responsibility for police custody healthcare services across the South East from the Police Forces.

21. Commissioning plans for the next five years need to address these priorities. They also need to be flexible, with contracts capable of being adapted to meet changing circumstances and any shifts in the policy directions of the various external bodies and agencies involved in health and justice. For example, changes in the use of the custodial estate (for example from a prison to an

immigration and removal centre) can happen at short notice; leading to a fundamental change in the health needs profile of the people who will be accommodated there.

22. Commissioners also need to consider the on-going development of the market for the provision of healthcare in justice settings, ensuring that there are sufficient providers able to offer quality, innovation and value for money.

23. Commissioners need to commission innovative solutions to challenging problems, seeking solutions in a different way. Locally this will mean exploring the potential use of medical technology within prisons in order to reduce the need for costly and timely Escorts and Bed watches and in term reduce delays in receiving secondary healthcare out-patient care. Integration of street triage with liaison and diversion services in support of mental health crisis concordat work is also being considered.

Prisons / YOI's / Secure Training Centre

24. Surrey Prisons will have a new GP service and Mental Health service starting 1st April 2015 and HMP Lewes will have new primary care and GP Provider from 1st April 2015; ensuring effective implementation and transition is key alongside robust performance management against services specified.

25. Transfer of commissioning responsibility from Youth Justice Board to NHS England on 1st April 2015 for Secure Training Centres will require the re-procurement of existing health services at Medway STC during 2015.

26. Health & Justice Indicators of Performance are a requirement of all adult prison contracts now across the South East and therefore each contract will be monitored using these indicators alongside our local KPI Suites.

27. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	Aspirations	Operation actions	Outcomes
Reduced Prison Officer availability for Escorts and Bed watches and enabling prisoner access to internal healthcare appointments	Escorts for all Prisoners who require a hospital appointment	Reduce the number of escorts by bringing services into the prison, develop medical technologies. Continue dialogue with NOMS	18 and 2 weeks waits for treatment met
Workforce; Clinicians and Medics not applying for jobs in prisons	To have a workforce that is fit for purpose	Assist providers in thinking creatively about staff models and recruitment approaches	Les reliance on Locums and agency provision
Aging prisoner population	Social care and healthcare needs for all prisoners are met or equivalence with the community	Estate capital adjustments required (NOMS requirement) to enable Health & Social care to provide a package of care	Equivalence with the community
Access to Consultation and	Clinicians getting access to patients	Formal notification of impact to the YJB	Reduced DNA's and cancelled

Clinical Rooms at YOI Cookham Wood	and then being able to see patients in an appropriate setting		appointments due to access to patients / room availability
Commissioning a Provider of high quality healthcare services into Medway Secure Training Centre	Provision of high quality, integrated healthcare provision	Market development and Provider stimulation. Re-procurement of existing health services	Delivery of excellent healthcare services for children and young people at Medway STC
Highly complex Children within the Secure Estate	To work with Secure Commissioners to ensure rapid access for those requiring CAMHS tier 4	Continue in dialogue with Specialist Commissioners	The most vulnerable children accessing appropriate services

Sexual Assault Referral Centres (SARCs)

28. The South East will continue its involvement in the national programme of Sexual Assault Services development and the coordination of the South East response to the national work commissioned by NHSE examining pathways and 'who pays' for which elements of the SARC services offered. This relates to both the acute / forensic provision and the aftercare services.

    - Liaison and close working with colleagues at Police & Crime Commissioners Office in order to support their continued engagement in and funding of both Adult and Child ISVA provision.
    - Liaison with Providers, Police colleagues, Local Authorities and Service Users to develop local KPI are that reflect qualitative issues rather than quantitative data with regard to SARC services.
    - Implementation of sustainable, efficient and effective Paediatric SARC s across the South East which reflect the National Paediatric SARC Framework.

29. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	Aspirations	Operation actions	Outcomes
Lack of clarity regarding commissioning responsibility for different element of the victims' journey.	To get a clear understanding of who is responsible for commissioning different aspects of the victims pathway and work in partnership with other agencies to ensure appropriate and relevant services e.g. Talking Therapies.	To await national guidance. To understand the impact and requirements for each SARC within the South East and the aftercare services in partnership with Providers and other Commissioners. To liaise with other agencies e.g. LA, CCG & Police to ensure appropriate services are accessible to victims.	National Guidance is implemented across the South East area. Victims have a choice of services to meet their individual needs. Multi Agency relationships are in place and effective.

Availability of Paediatric Sexual Assault Examiners to delivery best practice service to victims	To provide timely access to high quality, specialist, age appropriate Paediatric Sexual Assault Examinations and aftercare services	To complete an engagement exercise with Paediatricians and Clinicians to inform Service Models for each of the 3 geographical areas, co-development of model and service specification following wider stakeholder engagement on proposed Clinicians model. Followed by procurement of 3 Paediatric SARC services.	Provision of Paediatric SARC services across the South East that reflect national guidance and best practice.

Police and Court Liaison & Diversion (PCLD)

30. The scaling up of the PCLD programme within the South East to meet the national service specification requirements and will predominantly involve for Wave 2 sites (Kent and Surrey):-

- Widening the range of vulnerabilities beyond mental health (i.e. covering learning difficulties, substance misuse and other health and social care vulnerabilities
- Developing an all age service (youth and adult provision)
- Providing a service across all police custody suites and courts (with a core team of staff in place in both police custody suites and courts to identify and screen vulnerable offenders)
- Delivering a 24/7 service where need is indicated

31. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	**Aspirations**	**Operation actions**	**Outcomes**
Recruitment of workforce to deliver the national service specification	To recruit high quality, permanent staff into all roles	To continue to work closely with Providers on developing local workforce and encouraging Practitioners into the court and police custody environment	Implementation of an equivalent liaison and diversion service across the South East by April 2015

Procurement Plan

32. The South East Health and Justice Commissioning Team intend to undertake the following procurements during 2015/16. The following table gives an indication as

to the procurements required and the timeline. Continued resources for procurement are required from 1.4.2015 for the project management and procurement advice to ensure delivery.

	Procurement	Process to commence	Anticipated Contract Start Date
1	Surrey SARC	March 2015	April 2016
2	Medway STC	March 2015	October 2015
3	Surrey / Sussex / Kent Police Healthcare	May 2015	April 2016
4	HMP Bronzefield SMS	April 2015	April 2016
5	HMP Ford SMS	October 2015	October 2016

Financial context

33. In 2014/15, a surplus of £2.0m is projected in line with submitted plan. This surplus will be carried forward into 2014/15.

34. The service has received an increase in allocation, including a net 0.6% for growth adjusted for efficiency and additional funding for the Gatwick Immigration Removal Centres.

35. The service is planning new investments in Paediatric Sexual Assault Services in Sussex and Kent and increasing its investment in Mental Health provision in Surrey. Responsibility of healthcare in Secure Training Centres transfers to NHS England in 2015/16 and funding is anticipated from the Youth Justice Board. There will be increasing coverage of Police and Court Liaison and Diversion Services as Surrey and Kent move into Wave 2 of the national pilot. Funding for this currently sits within the central team and is still to be allocated.

36. Planned Surplus for 2015-16 is £2.3m in line with business rules.

37. The summary financial position is shown below:

Health & Justice	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	44,521	47,079
Part year effects	-1511	267
Sub total	**43,010**	**47,346**
Inflation uplifts	870	922
Growth	8	199
Provider Efficiency	-129	-666
Service Investments	4,034	3646
QIPP	-714	
Total	**47,079**	**51,447**
Notified Allocation	49,111	51,730
Surplus carried forward	0	2,030
Total Resources	**49,111**	**53,760**
Surplus	**2,032**	**2,313**

38. The following table summarises the investment in Kent and Medway Section 7a programmes:

	2014/15				2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**		**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Health & Justice	49,111	47,079	2,032		53,760	51,446	2,314

39. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for health and justice commissioning. These indicators and the planned performance identified in the plan remain valid.

PRIMARY CARE SERVICES

40. The delivery of core primary care services is largely covered through nationally negotiated contracts (e.g. general medical services (GMS) contracts) or nationally determined regulations (e.g. regulations governing the process for reviewing applications to open a new community pharmacy).
41. NHS England's ambition is to deliver, through excellent commissioning:
    - A common, core offer for patients of high quality patient-centred primary care services.
    - Continuous improvements in health outcomes and a reduction in inequalities.
    - Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda.
    - The right balance between standardisation/consistency and local empowerment/flexibility.
42. NHS England believes the areas discussed in this plan can be used to draw some conclusions on the future configuration and role of general practice. These conclusions are emerging and will need to be kept under ongoing review.
43. It is suggested that general practice is on a journey that will take it along a development path, progressing through a number of stages:
    i. Current state
    ii. An extended skill mix in practices and across a range of primary care providers
    iii. Federation of practices
    iv. Co-location of practice / merger of practices to form larger partnerships / primary care units

v. Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations), many operating as accountable care organisations

44. The following table provides more detail of the strategic intentions for the key primary care services:

General practice	General practice is the cornerstone of the NHS. Improving the nature of services provided outside hospital and supporting the public in self-care will be key ingredients for a sustainable NHS. Transformation in general practice must seek to maintain the internationally recognised strengths of the general practice model. Improving access is a priority, ensuring prompt access to GP services through 111, services that are available from 8am to 8pm seven days a week, and more rapid response to patient concerns through the use of telephone consultation. There will also be more personalised care and equality of access to services for everyone irrespective of where they live or their social status. We will work with CCGs, providers and other partners to identify and address inequalities. To achieve these ambitions will require a more scaled-up approach to general practice. This will mean working towards fewer, larger practices or federations or groupings of smaller practices where expertise is pooled and there can be increased focus on efficiency and innovation. This will enable patients to have seven-day-a-week access to a greater range of high quality primary care services. There will also need to be increased capacity in general practice and workforce plans need to include realistic projections for the number of GPs and practice nurses required, taking consideration of the presently aging workforce and changes in the career aspirations and expectations of newly qualified staff. Data and information are fundamental to providing high-quality, personalised care, improving productivity and empowering patients and clinicians to transform local services. It will be essential that GPs are supported by effective, efficient and integrated information technology systems. Patient access to electronic health records has been shown to improve health outcomes and reduce workload and costs so in line with the national strategy this will be supported. Online consultations in selected situations are also proving safe, effective and can improve patient confidentiality while reducing costs so will be facilitated. Primary care services operate within communities and have strong links with the voluntary sector and community services. Strengthening and further integrating these can ensure resilient healthy communities addressing the root causes of ill health.
Community pharmacy	Community pharmacy will be increasingly used for urgent minor complaints, as part of an integrated urgent and emergency care system, reducing the pressure on general practice and A&E.

services	Working with the LPC to ensure that we have the right number of pharmacists, with the right roles, working from the right locations will be important if we are to take advantage of the opportunities to provide a wider range of professional services from community pharmacies.. Increased mechanisation of dispensing will be supported to free up time for more proactive health interventions.
Dentistry	NHS England commissions dental services in both primary and secondary care, providing an opportunity to commission services across the whole patient pathway. We will look to move work such as minor oral surgery out of secondary care to primary care where we can so it is closer to home and more convenient for patients. We will also work with primary care dental providers and through the LPC to ensure that referrals continue to be made and handled appropriately.
Optometry	Many services provided in secondary care ophthalmology, such as for glaucoma and special needs optometry, could be carried out more efficiently and conveniently in high street optometry services. Core contracts for optometry will be developed and refined with the LPC and we will work with CCGs to co-commission services that can be moved from secondary to primary care.

45. Our aim is to create sustainable NHS services that provide more integrated care for patients, built around the registered populations served by groups of practices. To do this NHS England is developing joint and co-commissioning arrangements for commissioning with CCGs and also with local authorities who hold some primary care contracts.

46. It is important that this co-commissioning approach is developed to ensure the right balance between standardisation and flexibility in order that local primary care services can be planned in the context of CCGs' commissioning strategies, health and wellbeing strategies, JSNAs, PNAs and so citizens and communities can influence and challenge how services are provided.

47. We will work with Health Education England to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment. This includes supporting the rollout of national and local workforce tools to support workforce planning.

Primary care support services

48. NHS England is responsible for primary care support (PCS) services and wants all practitioners to have access to a standard range of modern, efficient and effective PCS services without the current variations in quality and cost. NHS England is continuing to work with staff and stakeholders to achieve the required changes in PCS services, through a market testing exercise.

Secondary care dental

49. National criteria and care pathways are currently being developed by NHS England for all dental specialties following which commissioning of secondary and primary care services will be reviewed. Until these are in place steady state commissioning will continue with existing providers.

50. Referral management arrangements are in place for oral surgery and endodontic treatment as ongoing QUIP delivery. Once national care pathways are in place, it is anticipated that further referral management will be introduced for other dental specialties.

Commissioning Intentions

51. Attachment 9 details the 2015/16 national and NHS South primary care commissioning intentions.

52. Locally, NHS England is committed to ensuring patients can access high quality GP services that meet the needs of our local communities. We will work with CCGs and other stakeholders to review and either extend (where there is flexibility to do so), re-procure or decommission those existing Alternative Provider of Medical Services (APMS) contracts and services which are scheduled to end at various points during the next two years (up to 31st March 2016). The following APMS contracts are scheduled to end during the next two years are:

Practice Name	**CCG Area**
DMC Sheppey Healthcare Centre	Swale
DMC Walderslade Surgery	Medway
College Health-Boots	Medway
College Health –Sterling House	Medway
DMC Medway Healthcare Centre	Medway
The Broadway Practice	Thanet
White Horse Surgery and Walk-In Centre	Dartford, Gravesham and Swanley
Minster Medical Centre	Swale
The Sunlight Centre	Medway

53. NHS England (Kent and Medway) has a relatively high percentage of general practices on General Medical Services (GMS) contracts. In this respect 82% of GP contractors across Kent and Medway hold GMS contracts with only 13% of practices holding Personal Medical Services (PMS) contracts and a further 5% holding APMS contracts. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health and NHS England from 2014/15) and the General Practitioners Committee (on behalf of the BMA).

54. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to

patient need, as well as CCG and NHS England strategies. A local review of PMS contracts was undertaken throughout 2012/13. The final phase of this review will be undertaken in 2015/16, will be to review the objectives of other PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.

55. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Reviewing and, if appropriate, re-procuring the occupational health service for GPs and other primary care contractors.
- Working with local authorities to support them to develop more healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Extending the delivery of flu vaccinations in community pharmacies in order to help boost take up of the vaccine amongst at risk patients.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.
- Reviewing and where appropriate re-procuring interpreting services to support patients in accessing primary care contractor services.

56. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for primary care commissioning. These indicators and the planned performance identified in the plan remain valid.

Financial investment

57. The following table details the investment in Kent and Medway primary care services:

	2014/15				2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**		**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Primary Care	373,093	369,611	3,482		382,229	378,743	3,486

PRESCRIBED SPECIALISED SERVICES AND SERVICES AND ARMED FORCES HEALTH

To be completed once further information received. See Attachment 10 for Prescribed Specialised Services summary plan

SUMMARY

58. This paper is an addendum to the Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, and updates the plan to take account of 2015 / 16 planning requirements.

59. The following table shows the total planned funding for the direct commissioning services that have been the responsibility of the Kent and Medway Area Team:

	2014/15				2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**		**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Primary Care	373,093	369,611	3,482		382,229	378,743	3,486
Public Health	51,523	53,966	-2,443		40,387	42,829	-2,442
Health & Justice	49,111	47,079	2,032		53,760	51,446	2,314
Total Kent & Medway	**473,727**	**470,655**	**3,072**		**476,376**	**473,019**	**3,358**

60. It is important that this plan is not read in isolation and should be read in conjunction with:

- Kent and Medway CCG two year operational plans
- The NHS England (Kent and Medway) strategic framework for primary care
- The Kent Annual Public Health Report
- The Medway Annual Public Health Report
- The Kent Joint Strategic Needs Assessment

- The Medway Joint Strategic Needs Assessment
- The Kent Health and Wellbeing Plan
- The Medway Health and Wellbeing Plan

61. For Health and justice healthcare commissioning and public health commissioning the strategic direction will largely be determined through national work programmes. Local plans will be shaped around these national documents but local strategic focus in the five year plans prepared with CCGs are likely to focus on:
    i. addressing any ongoing service performance issues;
    ii. through the gateway services for prisoners being released from prison back into the community; and
    iii. secondary care services for the health and justice population.
62. The strategic development of primary care is also being considered at a national level and through the establishment of co-commissioning arrangements with primary care.

NHS England

2015/16 Public Health Work Plan with Milestones

Objective	Success criteria: How will you know you have achieved the objective? What evidence will you need?	Actions	Milestones	Date	Achievement
Immunisation – improved coverage and uptake to reduce the incidences of outbreaks and avoidable disease	Coverage and uptake of childhood and adult immunisations meets national targets • 95% uptake of childhood immunisation programmes to ensure herd immunity • 75% uptake of flu vaccination in over 65 and under 65 at risk • Achievement of agreed targets for new programmes for childhood flu, adolescent Men C/university entrants, Shingles.	**Maternal Flu and Pertussis** Implementation of maternal flu and pertussis by community midwifery teams across Kent	Work with screening and immunisations team, CSU and maternity providers to deliver within community midwifery	June 2015	
		Immunisations:			
		Childhood Flu Implementation of school based programme 15/16 (subject to funding)			
		Options appraisal for establishing service.	Mini procurement of existing service or vary existing contracts to include in immunisation teams delivering schools based programme	Sept 15	
			Work with providers to ensure service models are robust	Apr – Sep 15	Awaiting funding announcement
		School Based Imms Review in year of school based Imms.	Work with key stakeholders to review full Imms and school nursing programmes	April 2016	
		Adult Flu Establish service models with pharmacies			

		and maternity			
		Men B introduction	Work with providers to ensure programme fully understood and implemented	TBC	Awaiting funding announcement
		Co-commissioning – impact on immunisation and screening services	Awaiting national guidance	TBC	
Screening – improved coverage and uptake to support early diagnosis and intervention and reduce avoidable ill-health	Ensure all screening programmes achieve national targets Ensure that the programmes achieve value for money and reach all the relevant screening populations including those hard to reach who traditionally don't access screening services	**Cervical Screening** Undertake an in-depth systematic review of the cervical screening programmes to identify existing provision, review costs and quality targets and make recommendations for commissioning in 15/16. Include access through CASH and women in the military.	Undertake review of services, identify where current contracts and resources are Identify where future investment maybe required and look for opportunities for re-commissioning.	Jun15 Sep 15	
			Undertake Joint Strategic Investigation with NW Surrey CCG to identify options for future for both the symptomatic and national screening services. Review existing pathways	Dec 14 Apr 15	In progress Awaiting

			for military services Identify where future investment maybe required and look for opportunities for re-commissioning.		review GS
Healthy Child Programme including Family Nurse Partnership Developed to ensure effective handover to Local Authority	Achieve trajectory target • 421 health visitors across Kent and Medway Commissioning responsibility ready to be transferred by October 2015.	Continue working with providers and Health Education England, to increase the number of health visitors as required by the national programme and to achieve consistently good outcomes as part of the Healthy Child Programme Ensure contracts are in place jointly with LA for the transfer of commissioning responsibility can happen by Oct 15 Handover of commissioning responsibility	Review Transition Board ToR Develop Transition Board Plans for transfer to ensure systems and processes in place ready for commissioning transfer by October 2015 Monthly review of provider workforce plans to ensure on track to hit trajectory Working with LA to ensure all legal requirements are met Jointly manage contracts with LA until Oct 15	Jan 15 Jan 15 On-going Feb 15 Apr – Sep 15	Achieved Achieved In process In process

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN 2015/16

Improved Child Health information systems and data quality	**Complete and robust data sources for children covering the entire child population in Surrey and Sussex**	**Work with Child Health Information Systems providers to ensure the data is accurate and the benefits maximised.**	**Programme Board to be established across all providers** **Deep dive reviews to identify gap in ability to deliver national spec** **Action plan to be developed based on new service specification**	**Jun 14** **March 15** **Mar 16**	**Achieved** **In progress**
Collaborative Working with CCGs on improving uptake and coverage for immunisation and screening programmes	Improved uptake of screening and increase in early diagnosis of disease particularly cancers	Ensure collaborative working with CCGs in line with CCG plans to improve early diagnosis of cancers	Establish working links with CCGs to identify how we can work collaboratively on specific issues across the area	Apr 16	In progress
6-8 NIPE Checks	Review delivery of 6-8 week checks undertaken by Kent and Medway GPs	Ensure 6-8 week checks are delivered and data reported to CHIS in a timely manner	Establish working links with GP leads, LAs and providers	April 16	In progress

ATTACHMENT 2: 2015/16 PUBLIC HEALTH COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

In 2015/16 NHS England is focusing on

- Improving access to public health screening programmes overall, and with a specific focus on improving access and uptake for people with learning disabilities, and women in the military.
- The transfer of commissioning responsibilities for the Healthy Child 0-5 Programme (Health Visitor and Family Nurse Partnership Services) to Local Authorities by October 2015.
- Working with stakeholders to develop a strategic approach to the future of the Child Health Information System to support the commissioning and delivery of services to children.
- Planning to use the national procurement framework for childhood flu. For adult flu we will increase delivery channels, e.g. pharmacies. Work with maternity providers to deliver clinics for pregnant women.
- We will also work with maternity providers to improve the uptake of pertussis.
- Engage with key stakeholders around access to cervical screening e.g CASH clinics.
- Review in year the delivery of school based immunisations, service model, outcomes and finances.
- Review NIPE 6-8 week check to ensure all GPs are appropriately trained and supplying data to CHIS.

Introducing Additional Services

- New Born Blood Spot Screening (NBBS) - expanded to screening for 4 more conditions. Completion of full national rollout was in Jan 2015
- Continuation of the temporary programme for maternal pertussis
- Meningococcal B – if vaccine procured at cost effective price
- Childhood flu vaccination programme extended to include 5,6 and 7 year olds (Key Stage 1)
- Rollout of cervical screening to women in the military

ATTACHMENT 3: 2015/16 PUBLIC HEALTH COMMISSIONING INTENTIONS (LOCAL)

The following are the key priorities for the Kent and Medway areas

- Immunisation
  - Data Quality
  - Childhood Flu – implementation of school based programme 15/16
  - Men B introduction
  - Co-commissioning
- Screening Programme Reviews –
  - Cervical Screening
- Transition of commissioning responsibility for Healthy Child Programme to Local Authority
- Child Health Information Service and Record Departments implementation of national specification
- Working with stakeholders to improve the delivery of the 6-8 week NIPE checks delivered by GPs across Kent and Medway
- Collaborative working with Clinical Commissioning Groups and CSU to improve uptake and coverage of immunisations and screening programmes and improve early diagnosis of disease particularly cancer

ATTACHMENT 4: PUBLIC HEALTH PROGRAMME AND POPULATION RISKS 2015/16

NHS England

Risk Identified	Description	Gross Risk Assessment (Pre-Controls)			Key Controls	Net Risk Assessment (Post-Controls)			Proposed Mitigation Measures	Target Risk Assessment (Post-Mitigation Measures)			Key Risk Indicator to be Monitored	Financial Impact Forecasts		
		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Pessimistic	Most Likely	Optimistic
Immunisation	Delivery of existing programmes not achieving herd immunity resulting in disease outbreak	4	4	16	A review of data collection processes identified data quality issue.. Potential solutions identified to improve quality of data	3	4	12	Once data quality is established, targeting support to providers struggling to deliver to national standards	2	2	4	Roll out and coverage of existing immunisation programmes Implementation plans to be reviewed and monitored by the Kent and Medway Immunisation and Vaccination Committees	£ to deliver better data transfer to improv e data quality	£K	£K
Immunisation	Delivery of new programmes not achieving required levels of immunity resulting in disease outbreak	4	4	16	Investigation of which providers are not achieving target immunity levels through analysis of robust information	3	4	12	Targeted support to providers struggling to deliver to national standards	2	2	4	Roll out and coverage of existing immunisation programmes	£	£K	£K

ATTACHMENT 4: PUBLIC HEALTH PROGRAMME AND POPULATION RISKS 2015/16

NHS England

Risk Identified	Description	Gross Risk Assessment (Pre-Controls)			Key Controls	Net Risk Assessment (Post-Controls)			Proposed Mitigation Measures	Target Risk Assessment (Post-Mitigation Measures)			Key Risk Indicator to be Monitored	Financial Impact Forecasts		
		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Pessimistic	Most Likely	Optimistic
Cervical Screening - Cytology.	Review of cytology as part of cervical screening pathway	2	4	8	A review needs to be carried out in 2015 to identify potential increase in activity within CASH clinics for Kent and Medway women who present for call and recall screening	2	4	8	Discussion will be needed with LAs to understand commissioning and financial implications	2	4	8		£	£	£
Healthy Child Programme (0-5) Family Nurse partnership safe transfer of commissioning responsibility	Local Authorities fail to agree financial envelopes as part of the transfer of commissioning responsibility	4	4	16	Review of workforce and education plans, monthly and quarterly reporting to NHS England Close working with Local Authority	3	3	9	Regular review meetings are held with providers on workforce and service planning. Close working with LA on plans, finance and legal issues	2	2	4	Numbers through monthly monitoring of Electronic Staff Records Audit of workforce to ensure all involved in delivery of HCP (0-5) Quality measures of service performance	£	£	£

ATTACHMENT 5: PUBLIC HEALTH KEY FINANCIAL RISK 2015/16

NHS England

Key Financial Risks

- Screening and immunisation programmes across Kent and Medway are based and delivered on a population base. Increases or decreases in the populations receiving screening or immunisation will inevitably impact on the cost of delivering the programmes.
- Over the next 3 years (2015-2018) the predicted changes in population age groups will have the following impacts requiring investment (or disinvestment):

Programme	Age Group	Predicted Change	Impact on commissioning
Cervical Screening Programme	25-49 years (female) 50-64 years (female)	?% increase 10% increase	Some investment is likely to be needed in the short term but this will reduce as HPV vaccination and testing takes effect.
Bowel Screening	60-69 years 70+ years	2% decrease 17% increase	Any reduction in the 60-69 age groups will be offset by increase in age extension. New developments in initial screening process that increases sensitivity & specificity of testing and for bowel scoping will require investment
AAA Screening programme	65 year (males)	15% decrease	Steady state (possible disinvestment)
Diabetic Eye Screening	All Ages	4% increase in population also increase in prevalence	Investment required
HPV vaccination programme	12 year (females)	10% increase	Investment required
Childhood Immunisation	Children up to 12 years	4% increase	Investment required
Flu immunisation	Over 65 years	10% increase	Investment required
Shingles	70 years 79 years	25% increase 11% increase	Investment required

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

NHS England

Prisons

1. As of March 2015 the prison population in the South east was 8,865. This is not a static population; it ranges from those in custody on remand for a matter of days to those in prison for life with associated long term needs.

   - Nationally 70% of adult prisoners said they had used illicit drugs prior to entering prison;
   - In a survey of prisoners released from custody, 12% of prisoners said they had a mental illness or depression as a long-standing illness and 20% reported needing help with an emotional or mental health problem.
   - The age profile of a middle aged prisoner reflects that of someone 10 years their senior in the community. Thus there is a high prevalence of long-term conditions. The older prisoner population is generating emerging social care needs.
   - Female prisoners are more than three times as likely to self-harm as male prisoners.
   - The rates of smoking, drinking and use of illegal drugs are substantially higher among young offenders than among young people who do not offend.

2. Within the South East there are 15 prisons:

Prison	Type	Provider
HMP Elmley HMP Swaleside HMP Standford Hill	Cat C; Op Cap 1252 Cat B; Op Cap 1112 Cat D; Op Cap 464	IC24 – Primary Care Nursing GP - Minister Medical Practice Oxleas – Mental Health, Pharmacy RaPT – Substance Misuse
HMP/YOI Rochester	Cat C; Op Cap 658	Oxleas – Primary Care Nursing , GP, Mental Health, Pharmacy RaPT – Substance Misuse

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

HM YOI Cookham Wood	Cat B Local; Op Cap 200	Oxleas – Primary Care Nursing , GP, Pharmacy CNWL – Mental Health KCA – Substance Misuse
HMP Maidstone HMP East Sutton Park HMP Blantyre House	Cat C Foreign Nationals; Op Cap 650 Cat C / D; Op Cap 100 Cat C / D; Op Cap 122	Oxleas – Primary Care Nursing , GP, Mental Health, Pharmacy RaPT – Substance Misuse
HMP Lewes HMP Ford	Cat B; Op Cap 750 Cat D; Op Cap 557	Sussex Partnership Trust – Primary Care Nursing, Mental Health, Pharmacy CRI – Substance Misuse MedCo – GP Sussex Partnership Trust – Primary Care Nursing, , Mental Health, Substance Misuse, Pharmacy Dr Robertson / Dr West - GP
HMP High Down HMP Down View HMP Send	Cat B Local; Op Cap 1103 Cat C /D; Op Cap 355 Closed Female; Op Cap 282	Virgin – primary care nursing, Pharmacy CNWL – Mental Health RaPT / KCA – Substance Misuse Acor –GP *As above but different GP Provider* Cheam Practice – GP

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

HMP Coldingley	Cat C Trainer; Op Cap 513	Cheam Practice – GP Studholme Practice - GP
HMP Bronzefield	Cat B Female; Op Cap 527	NOMS Commission Sodexo for healthcare, NHSE commission; CNWL – Mental Health Sodexo Justice Services – Clinical Substance Misuse

Police Custody

3. HNAs have been undertaken in both Sussex and Kent and Medway custody suites. The same will be undertaken in Surrey over 2015/16. The number of detentions in custody across the South East is declining as the police continue to use alternatives to arrest including community disposals, restorative justice and voluntary attendances. However, the following is of note:

    - Approximately 37.1% of individuals in Kent and 40% in Sussex are seen by the healthcare provider whist in custody. This is comparable to other forces nationally.
    - The largest issue facing healthcare providers in Kent & Medway and Sussex custody settings is substance misuse. 34% of contacts in Sussex and 38.1% of contacts in Kent and Medway related to substance misuse. However using the same methodology on current performance indicates closer to 54% - nothing that this figure will include multiple contacts with the same DP.
    - Mental Health concerns are also a significant issue in forces representing 16% of contacts with healthcare provider in Sussex and 8.2% of detainees in Kent presenting with an issue.

4. The following number of police custody suites in each area:

Force Area	Number of Custody Suites	Provider

Kent	7	Kent Police
Surrey	3	Tascor
Sussex	6	Tascor

Sexual Assault Services

5. Across the South East there are 3 Sexual Assault Referral Centres. All of the SARC's are jointly commissioned with Police. The key points of note are as follows:

- Analysis by the MOJ statisticians revealed that of the estimated 78,000 victims of rape or attempted rape each year, 9,000 are men, equating to 1 in 10 victims being male. They also revealed that 72,000 males were recorded as being victims of sexual offences annually.
- Although reporting of sex crimes against males is evidentially on the increase, academics and professionals in the field of interpersonal violence agree that sexual abuse and rape of males is one of the most under reported crimes worldwide. In 2012/13 only 1,550 incidents of male rape were recorded by the Police in the UK, equating to a staggering 7,450 rape or attempted rapes of males going unreported. These figures are reflected in both Kent where only 11% of reporting rape victims were men and in Sussex where on 4.2% of victims accessing the SARC were men.
- Over 90% of referrals to the SARCs in Kent and Medway and Sussex are made by the Police.
- The NSPCC's 2011 report indicated that:
    - 0.6% of under 11s and 9.4% of 11–17s had experienced sexual abuse including non-contact offences in the past year
    - 65.9% of the contact sexual abuse reported by children and young people (0-17s) was perpetrated by other children and young people under the age of 18
    - Teenage girls aged between 15 and 17 reported the highest past-year rates of sexual abuse.
- Data from individual SARCs suggest that between 22% and 50% of clients seen are young people under 18 years old (NHS England, 2013, op. cit.).
- Sexual violence and abuse can cause severe and long-lasting harm to individuals across a range of health, social and economic factors. The effects of sexual violence on victims can include depression, anxiety, post-traumatic stress disorder, drug and

substance misuse, self-harm and suicide. In Sussex 53% of victims accessing the SARC were identified as having mental health concerns

6. The following details the Sexual Assault Referral centres in each of the three counties:

Force Area	Sexual Assault Referral Centre	ISVA Provider
Surrey	Care UK	RaSAC
Sussex, East Sussex and Brighton & Hove West Sussex	Mountain Healthcare Limited	Survivors Network Worth Services
Kent	Mountain Healthcare Limited	East Kent Rape Line / Family Matters

Children and Young People's Settings - Secure Children's Homes

7. There are two welfare only - SCHs in the South East Region and health needs assesments have been completed in each in 2014. Key findings are as follows:

- Children and young people in contact within the secure estate have more-and more severe – unmet health and well-being needs than other children of their age. They have often missed out on early attention to health needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems (Healthy children, safer communities, DH, 2009;Evidence of needs paper, Ryan M and Tunnard J, 2011).

- The children and young people who find themselves placed in SCH's have often taken high risks which will have had a detrimental effect on their health. This group of young people have often experienced significant abuse and/or are likely to have been a substance misuser, In addition to this they are likely to have engaged erratically with health services and have often missed significant health appointments.
- Physical health needs are generally minimal and well contained/managed
- Children now in SCHs are increasingly complex and have multiple unmet health needs. The reduction of the numbers of young people in custody nationally means that only the most vulnerable are now in secure environments.

8. The following identifies the secure children's homes within the South East:

Area	**Secure Children's Home**	**Provider**
West Sussex	Beechfield Secure Childrens Home, Copthorne	Sussex Community Health – Primary Care Sussex Partnership Foundation Trust – CAMHS CRI – Substance Misuse Services
East Sussex	Landsdowne Secure Childrens Home, Hailsham	East Sussex Healthcare – Primary Care Sussex Partnership Foundation Trust – CAMHS East Sussex County Council Substance Misuse

Children and Young People's Settings - Secure Training Centre

9. Medway STC is the only STC in the South East and has an operational capacity of 76 young people, both girls and boys. G4S are currently the provider of healthcare services and a re procurement for health services at the Centre is underway at the time of writing this document. A recent health needs assessment has indicated the following findings:

    - Since 2012 there has been a marked increase in the number of children and young people placed at Medway STC who have committed violent offences. There has also been an increase in the number of young people in the STC who have committed sexual offences and an increase in the number subject to MAPPA arrangements. In terms of the age of the cohort, there are more 17 year olds at Medway than previously, the data showing a year on year upward trend. Together these changes may mean a more challenging, complex and older group of children for staff to care for in 2014 than the cohort who were present in the STC in 2012.
    - The data provided by the YJB placements team shows higher than expected numbers of children and young people placed at Medway with a 'serious medical or health complaint' (7.54% in September 2014)
    - Youth Justice Board statistics appear to show an increase in the number of children and young people demonstrating a risk of self-harm or suicidal behaviour, now over double the figure reported in April 2013. There remain high levels of lower mental health need in combination with a concerning increase in the number of children and young people placed at Medway with severe mental health problems.
    - Data quality has been a significant issue in the collation of this report. SystmOne (or a parallel cohesive clinical IT system) is not yet in place in Medway. The number of late receptions into STC is currently impacting on the ability of staff to carry out the initial Comprehensive Health Assessment Tool (CHAT) screening within 2 hours of admission. This requires monitoring and further discussion at YJB/NHS England level; it is not a Medway specific issue but difficulty across a number of secure settings for children and young people at the moment.

Immigration Removal Centres

10. There are 3 IRCs and 1 Pre-Departure Accommodation (PDA) in the South East and recent health needs assessments have identified the following key findings:

    - Detainees require access to a full range of Mental Health services that are commensurate with the needs of those being detained, pending removal. Ensuring early interventions are available to ensure Mental Health issues are dealt with as early as possible.

- People with Mental Health problems are likely to stay in detention for almost twice as long as those who do not.
- Health promotion activities be delivered to ensure increased knowledge is available prior to departure.

11. The detainee population is unique and presents particular challenges for commissioners and providers in identifying and meeting health and wellbeing needs. The picture of health needs that emerges from the individual health and wellbeing needs assessments is of a population that is highly stressed due to their particular circumstances and the fact of being in detention. The following is also of note:

- The potential for communicable diseases to spread or go unchecked due to the likelihood of detainees not having received childhood immunisations;
- Aggravation of long term conditions e.g. diabetes due to detainees having avoided contact with formal healthcare services prior to being detained and/or the lack of access to appropriate health services in their home country;
- High levels of stress resulting in poor mental health and associated physical problems e.g. skin disorders, lack of sleep etc.;
- Risk factors associated with poor health including smoking, alcohol and drug use;
- Cultural and religious barriers making early identification and treatment of sexual and blood borne viruses problematic in particular HIV/AIDS

12. The following details the IRCs within the South East:

Area	**Immigration Removal Centre**	**Provider**
Sussex (Gatwick)	Tinsley House – Op Cap: 448 Brook House – Op Cap: 153 Cedars Pre-PDA for family units – Op Cap: up to 54 (9 units holding max of 6 detainees)	G4S – primary care and GP service Sussex Partnership Foundation Trust – mental health
Kent	Dover – Op Cap: 380	IC24 – primary care and GP service Oxleas – mental health and Pharmacy

		RaPT – Substance misuse

Police and Court Liaison & Diversion

13. Police and Court Liaison and Diversion (PCLD) services exist to identify offenders who have mental health, learning disability, substance misuse and/or other vulnerabilities when they first come into contact with the criminal justice system.

14. The need for greater consistency and coverage of Criminal Justices Liaison and Diversions services was highlighted in the Bradley report. The ambition is to have 100% coverage of the country by L&D services by 2017, subject to final approval by HM Treasury.

15. In the South East PCLD services were being commissioned historically but have benefited from being Wave 1 and Wave 2 pilot schemes where additional resources have been received to ensure that pre-existing services now meet the national specification requirements for the service.

16. The National Programme commenced in April 2014 with ten trial sites across the country implementing the national, standard service specification and standard, Sussex was one of these sites. The trial sites were selected on their perceived readiness and ability to scale up their existing PCLD provision to meet the new National Service Specification for L&D.

17. A further wave of trial sites has been announced which will receive 1-year funding from April 2015 to do the same. By April 2016 this means that over 50% of the country will be covered with L&D services that are working to the National Specification.

18. The following shows the healthcare providers that provide services in the police custody suites in the three counties and their status against national service specifications:

Area	Provider	Meets National Specification
Kent Force Area	Kent and Medway Partnership Trust	Yes – from 1.4.15 Wave 2

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

Surrey Force Area	Surrey and Borders Partnership Trust	Yes – from 1.4.15 Wave 2
Sussex Force Area	Sussex Partnership Foundation Trust	Yes – from 1.4.14 Wave 1

ATTACHMENT 7: HEALTH AND JUSTICE SUMMARY PLAN 2015/16

NHS England

5 Year Strategic Plan and Vision

Working together to achieve excellence in health outcomes and experience in justice settings for people in Kent, Surrey and Sussex

Priority One
To reduce health inequalities and improve the health outcomes for people in contact with the justice system through provision of high quality services that are equivalent to community services

Performance management framework
- Active management of contracts to a set of standardised quality criteria
- Consistent improvement in patient valued outcomes

Pathway review
- Ensuring integration across pathways

Overseen through the following governance arrangements
- Surrey and Sussex Criminal Justice Board and Kent Criminal Justice Board
- Informed by the Strategic Clinical Network for Health in the Justice system and for Mental Health
- NHS England, Kent and Medway Executive Team (Direct Commissioning Assurance)
- NHS England Health and Justice Oversight Group
- Local Authority (Overview and Scrutiny Committees)

Priority Two

Reduce Re-offending

Multi agency working and planning to enable Transforming Rehabilitation
- Understanding workforce requirements
- Reducing duplication of work

Measured using the following success criteria
- Number of offenders going back through the system.
- Sustained engagement with CRC and NPS – no offending within a 12 month period and no duplication of services offered

Priority Three
Strengthen leadership and patient voice to inform and improve the efficiency and effectiveness of services delivered through increased joint planning, collaboration and commissioning with commissioning partners

Early interventions and prevention
- Increase brevity of Liaison and Diversion
- Formalise and better describe to patients opportunities for access to Screening and Immunisation Services

Commissioning improved health in justice outcomes
- Moving towards a single framework
- Embed patient voice and engagement in service developments and the commissioning cycle

Improving victim experience and outcomes
- Evidence of working with vulnerable people
- Listening to and understanding the support they need

High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Data collection – consistency; measuring agreed outcomes.
- Expertise available to support the patient voice and engagement in justice settings
- Engagement with key stakeholders to ensure the success of the strategy and encourage joint commissioning where appropriate

System Objective Four

Value for Money

Assure partners, patients and the public that resources are well targeted, adequate and offer the best outcomes for patients
- Increase available benchmarking tools
- Evidence HNA's inform service design

How we seek assurance
- Regular, local Finance meetings with Providers and Area Team Finance colleagues
- Ensure HNA's are current and public health information informs targeted spend
- Engage in regular benchmarking activity and where necessary testing the market to ensure Value for Money for services provided

ATTACHMENT 8: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Implement Best Practice Mental Health Pathways of care in Prisons and YOIs that link with community mental health services	Review existing mental health services in prisons and YOI's to ensure they offer primary care mental health services which reflect the Stepped Care Model reflected in 'Improving Access to Psychological Therapies' (IAPT) services in the Community. Ensure that secondary care mental health services reflect standards of best practice in care. Embed patient outcome monitoring. Monitor timely Section 47 and 48 transfers under the Mental Health Act for prisoners experiencing a mental health crisis who meet criteria under the Act	Review existing service specifications to include primary mental health care services and patient outcomes monitoring.	All Providers of mental health services in prisons and YOI's	Where there is an absence of primary care mental health service Commissioners will need to either move existing resources to promote early intervention and prevention or identify new resources.	Recent ministerial interest has indicated a political drive to improve mental health services in prisons and uptake in Treatment Orders (CTO's, MHTR's) in the community.
Transfer of commissioning responsibility from Police Forces to NHS England	Implementation of the transfer of commissioning responsibility from Police Forces to NHS England by 1st April 2016 – this is reflected in the completion of the Statement of Readiness documentation And its requirements	By 1st April 2016, where contractually possible implementation of the new, standard, national service specification for healthcare services provided into Police Custody Suites. Budgetary and commissioning responsibility for healthcare services into Police Custody transfer to NHS England by 1st April 2016.	All Providers of Healthcare into Police Custody Suites	Should be cost neutral but relies on negotiations between Department of Health and the Home Office	Transfer of commissioning responsibility delayed by 12 months in order to enable all Forces to be ready and able to transfer to NHS England and provides time for cost and budget negotiations to be completed between DH and HO.

Implement effective co-commissioning of Sexual Assault Services for children aged 12 years and under and young people and adults aged 13 years and over.	The effective provision of SARC services relies on effective co-commissioning relationships between a number of Agencies; NHS England, Police Forces, Police and Crime Commissioners, CCG's, Local Authorities. Proactive engagement with Agencies by NHS E will be essential in their role as lead commissioner for the service.	Implementation of the Service Framework for Paediatric SARC Services and implementation of the 13 years and over National Service Specification for SARCs with supporting KPI Suite. This may result in the need to retender some SARCs during 2015/16,	All Providers of SARC's and their associated services.	Uplift provided by DH to support improved service provision od SARC's nationally – particularly for Paediatric provision.	On-going work confirming the financial responsibilities of each co-commissioning agency will provide greater clarity around funding responsibility when partners review existing services.
Implementation of National Health and Justice Performance Indicators	Ensure Providers of health services in criminal justice settings implement the national HJIP Framework for their particular setting when they become available. A national suite of HJIPS for prisons is available and being implemented; HJIPS for IRC's, YOI's and STC's and Police Custody are being developed.	Requires IT systems and templates to populate the indicators	All Providers of healthcare services in criminal justice settings.	Providers may have to resource time in training their staff in populating the HJIP template, learning READ codes., collating data returns and putting the HJIP template onto their computers.	Implementation of the national suite of HJIPs for adult prisons is well underway. Other settings are developing their own, bespoke data suites for implementation during 2015 / 16.
Providers continue to improve the coverage and uptake of health checks	Commissioners continue to review and monitor the delivery of Health Checks in prison	Implementation of Service Specification for Health Checks in prison.	All Providers of primary health care services in prisons.	Cost neutral as built into existing primary care contracts as a requirement.	Training needs of staff and ensuring consistency of what services are offered within the Health Check and how they are recorded is an important feature.
Strengthen the integration and continuity of care between custody	Healthcare Providers in criminal justice settings work with new Community Rehabilitation Companies to deliver continuity of care for prisoners on release –	Sharing of the service specification and model of provision being offered by	All Providers of healthcare services in prisons and	Cost neutral as an expectation within existing Provider contracts.	A national policy that will require close partnership working across a variety of local Agencies. Prison

and the community	reflecting 'Transforming Rehabilitation' agenda and 'Through the Gate' national policies Police and Court Liaison and Diversion Services continue to develop in line with the national service specification.	CRC's to enable prison healthcare Providers to engage and support the 'Transforming Rehabilitation' agenda.	YOI's.		based Providers must learn to be 'outward' facing.
Improve the proactive detection, surveillance and management of infectious diseases, outbreaks and incidents	Services will review and improve systems for the detection of TB, implement care pathways and processes for the screening, diagnosis and treatment of Hep B, Hep C and HIV, enabling the full roll out of opt out BBV testing by 1st April 2017.	Performance management of existing contracts by Commissioners to ensure delivery and review of specifications to ensure adequate purchasing of services.	All Providers of primary health care.	Potential cost implications where robust services and level of provision do not meet national expectations.	A phased roll out of BBV opt out is active nationally. Commissioners have undertaken local stock takes of their current positions against this requirement in order to determine any local additional resource implications.
Support the delivery of the Social Care Act in prisons.	Commissioners and Providers will support the prison and Local Authorities in the development of systems and services that deliver integrated health and social care.	Provision of social care assessments and interventions for prisoners commissioned by Local Authorities from April 2015.	Providers who may want to be delivering social care assessments and interventions by LA's	None	Variable approaches to provision of social care services to prisoners by Local Authorities nationally i.e. some will provide the service directly; some LA's will commission the services from existing prison Providers of healthcare.
Management of medicines and new psychoactive substances	Prescribers will proactively and continually review their prescribing practice and will introduce the new national formulary for pain management in prisons when published. Implementation of Best Practice Guidance in management of medication queues	Where not already in place implementation of national formulary and best practice guidance.	All Providers of Pharmacy services and Substance Misuse Services working with New	Expected to be cost neutral to NHS England	Close partnership working with Prison Service colleagues will be essential in delivering responses to NPS, reducing the use of some addictive medicines for the treatment of pain

	Implementation of Best Practice Guidance regarding new psychoactive substances		Substances.		
Improved response to managing prisoners at risk of serious self harm	Insist that Providers; ensure that Risk is highlighted and early intervention offered and available. Improve management of prisoners at risk of serious self-harm by implementing lessons learnt from Near Misses, local review of ACCT interventions and implementation and repeated monitoring of the implementation of Death in Custody recommendations consistently across Agencies	Reviewing with Partners how effective ACCT implementation is in each establishment, workforce training needs, quality of mental health services offered(i.e. timeliness of access, range of interventions offered) and how robust implementation of Lessons Learnt and PPO recommendations is will influence future service specifications for services and strategies for reducing the likelihood of self-harm and self-inflicted deaths.	All Providers in prisons and YOI's	None anticipated.	This intention is one that can only be delivered in partnership with stakeholders and is far reaching in identifying and supporting improvements in services which minimise the likelihood of serious self-harm and suicide.
Reduce the levels of smoking amongst prisoners	Ensure the consistent implementation of both Smoking Cessation courses, equipment, aids and peer support programmes in secure settings.	Review of service specifications to ensure compliance with expected national standards. Close working with Public Health colleagues to support the increased number quitters.	All Providers of primary care services in prisons and YOI's.	Some additional costs may be experienced where services are not adequate to meet the range of interventions needed ie peer support, NRT.	Preparing for and working closely with PHE will support prisoners and prisons when the settings move to totally smoke free environments.

Ensure Excellence in Delivery of Healthcare Services for Children and Young People	Continue to ensure that the Comprehensive Health Assessment Tool (CHAT) , AssetPlus (an end to end youth justice assessment framework) and SystemOne is implemented in Secure Training Centres and Secure Children's Homes Ensure robust Clinical Substance misuse services are in place in YOI's, SCH's and STC's Ensure the implementation of Standards of Care for CYP in Secure Settings is implemented, audited and actively reviewed	All service specifications should now reflect these requirements and all Providers of CYP services should be actively delivering the expected national standards	All Providers of CYP healthcare in secure settings.	Some additional costs may be experienced where services are not adequate to meet the range of interventions needed or standards expected.	Implementation of the standards for CYP services is being delivered throughout 2015/16

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Service User Story	Development of a Service User Story with poem / art work and a short film to use alongside recruitment campaigns for healthcare professionals into Criminal Justice Settings	A new product to use alongside mainstream recruitment campaigns to address workforce shortages in the criminal justice setting	All Providers in Criminal Justice Settings	Funding identified and planned for in 2015/16	A service User in Recovery from active addiction after 17 years has been released from prison and tells their experience of health services within criminal justice settings.
Implementation of Recommendations made by User Voice	Implementation of Recommendations made by User Voice who are undertaking a stock take of how South East H&J Commissioning supports the involvement, engagement and active inclusion of people who use health services in the criminal justice system can inform, influence and help deliver the local Commissioning Programme of Work	Service User and Patients by Experience lead our work plan development and help deliver its outcomes.	All Providers in Criminal Justice Settings in the South East.	Funding identified and planned for in 2015/16	Report with Recommendations expected by May 2015.
Sexual Assault Referral Service for children under 13 years (SARC) Kent, Surrey and Sussex	To commission fit for purpose Paediatric SARC Services in Kent and Sussex and seek reassure of quality of care pathway and service in Surrey To commission bespoke HNA's for Paediatric Sexual Assault in each of the 3 geographical areas	The key stages of the work are service design, development of a Kent and Sussex specific options paper, consultation and procurement of Paediatric SARC services. Sussex Paediatric SARC Services have progressed into developing a bespoke	Services delivered on a cost per case basis, anticipate there will be a limited impact on current providers due to low volume	Funding has been identified for the health element of the paediatric SARC from budget uplift received	National funding arrangements, roles and responsibilities across Partners to be clarified

		service specification and Kent Paediatric Service is to start engagement with Clinicians in service design.			
Surrey SARC	To re procure Surrey SARC	To meet national service specification , KPI and Quality measures	Care UK	Cost neutral	Existing Providers contract requires a procurement during 2015 for new service delivery April 2016
Surrey and Sussex Police Forces Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (South East) for 1st April 2016 and the re-tendering of services for 1st April 2016.	Transfer of commissioning responsibility to NHSE requiring a re-tendering of existing services across Surrey and Sussex Forces. Requiring a proactive Market Development and Provider Stimulation event to ensure new services are in place from April 2016	Tascor	National Team confirming service value and transfer value of services from Police Forces to NHSE to ensure adequate resources are transferred to enable re-commissioning of services.	Preparing Statement of Readiness and organising Market Development and Provider Stimulation Event in early Summer 2014.
Kent Police Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (South East) for 1st April 2016 and the re-tendering of services for 1st April 2016.	Transfer of commissioning responsibility from Kent Police Force to NHS England requiring a re-tender of existing services which meet national specification requirements.	Kent Police are the Provider of the FNP service, FME's are employed on an individual contract	National Team confirming service value and transfer value of services from Police Forces to NHSE to ensure adequate resources are transferred to enable re-commissioning of	Preparation for procurement underway whilst confirming OPCC and Kent Police agreement to go out to competitive tender due to change in law not allowing Police Forces to be direct employers of healthcare staff.

			basis by Kent Police.	services.	
Surrey Public Prisons – mobilisation of 2 new contracts	Mobilisation of new GP Contracts and new Mental Health Service Contract across the 4 Surrey public Prisons	New Service specifications, KPI's , Quality Dashboard	CNWL Foundation Trust, Cheam Practice, Studholme Practice and Ancor Practice.	As a result of procurements savings will be made from April 2016.	Mobilisation of new services and ensuring fidelity to the new service specifications.
HMP Lewes	Mobilisation of new GP Contract and new healthcare contract	New Service specifications, KPI's , Quality Dashboard	Sussex Partnership NHS Foundation Trust MedCO	As a result of procurements savings will be made from April 2016.	Mobilisation of new services and ensuring fidelity to the new service specifications.
HMPs Kent and Medway : Clinical Substance Misuse Service	Mobilisation of new clinical substance misuse service across the Kent and Medway prisons Estate	New Service specifications, KPI's , Quality Dashboard – particularly new clinical approach to methadone maintenance / detox	RaPT	Cost neutral	New Provider of Clinical SMS Services – close monitoring required by Commissioner required – need to ensure best practice in methadone prescribing is followed
Secondary Care Technology HMPS	Use medical technology in prisons to enable access to pathways for secondary care treatment and assessment. To be trialled and developed with existing secondary care Providers at the Isle of Sheppey and Surrey prisons.	Service innovation and reduce demand for external hospital visits and improve timeliness of intervention	Local Acute Trusts	Cost neutral	Innovative work with partners which will develop capacity and commitment from Acute Clinicians to engage in this approach

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

Secure Children's Homes (SCH) – welfare only	Implement new CAMHS contract Review primary care services model in light of national expectations and implementation of CHAT Review of substance misuse support in light of national expectations	Service uplift to meet Royal College standards and national specification expectations	Sussex Partnership Trust Crawley Downs practice Sussex Community Trust, E. Sussex Healthcare CRI	Increase in available resources for comprehensive health services.	
Medway Secure Training Centre (STC)	Transfer of commissioning responsibility to NHS England from YJB for health services at the STC from 1st April 2015. Need to re procure health services.	Aim to re procure health services by April 2015 in line with commissioning responsibility transfer.	G4S	Anticipate no cost pressures to NHS England	Unsuccessful procurement of services in January 2015 now requires a re tendering exercise to ensure new service specification is in place as soon as possible after 1st April 2015.
Surrey and Kent and Medway Police and Court Liaison and Diversion Service (PCLDS)	Implementation of Wave 2 of the National Pilot of Surrey and Kent and Medway PCLDS	Uplift existing services to meet the national service specification requirements	KMPT and SABPT	Financial uplift to existing services for a 12 month Pilot from 1st April 2015	PCLDS exists across all of the South East – Wave 2 additional monies allows all 3 services to meet national requirements from 1st April 2015
Roll out E-prescribing across the Secure Estate	In line with national requirements roll out E-prescribing across the secure Estate in the South East	Paperless prescriptions, improved Information Governance	All Providers who Prescribe	Cost of implementation during 2015/16 planned for in budget	Programme of work with timetable alongside training for Providers funded by NHS E and delivered by North London CSU

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

Provision of new IT Hardware across Secure Estate	To provide all secure settings with a hardware refresh during 2015	New equipment enabling more timely use of information and data reporting and storing	All Providers in Secure Settings in South East	Cost of implementation during 2015/16 planned for in budget	Programme of work with timetable developed and live.
Implementation of System One (TPP) into; Secure Children's Homes, Immigration Removal Centre's and Medway Secure Training Centre	Implementation of System One (TPP) Electronic Patient Record system into all secure settings which Health and Justice Commission services into.	Allowing electronic record keeping that reflects national standards and requirements in these settings – similar to all other Secure Settings	Providers in SCH's, STC and IRC's	Cost of implementation during 2015/16 planned for in budget	Programme of work with timetable developed and live.
Implementation of standard Information Governance Audit Recommendations across HMPS in the South East	Implementation of recommendations provided to each HMPS site across the South East following an IG audit	Reduce the risks associated with non-compliance with legal Information Governance requirements. New expectations and new method of assessing Providers compliance.	All Providers of healthcare services in HMPS.	Cost neutral for NHS England – may require some investment from Providers e.g. staff training	Implementation of a Memorandum of Understanding (MOU) developed in information sharing between health Providers and non-health Providers in HMPS supports the audits findings

ATTACHMENT 10: 2015/16 PRIMARY CARE SUMMARY PLAN

NHS England

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Primary care: current landscape

1. *Variation in quality and performance*
2. *Some patients have difficulty accessing primary care services*
3. *Some patients struggle to navigate the health care system*
4. *Patients using hospital services inappropriately*
5. *Significant number of premises fail to meet required standards*
6. *Significant number of small practices managed by sole practitioner contractors*
7. *Uneven distribution of resources between practices and across CCGs*
8. *Community pharmacy plays limited role*

General practice in Kent & Medway: current landscape

1. *Registered population of circa 1.4 million*
2. *8 CCGs, covering populations ranging from circa 106,000 to 460,000*
3. *262 GP contractors, 34 PMS 13, APMS. 85% of practices are GMS – unusually high and limits scope of local QIPP*
4. *3 GP-led health centres . Their future is the subject of review by CCGs and the local area team*
5. *Some practice premises do not meet minimum standards*
6. *There are significant GP recruitment issues in parts of Kent and Medway.*

Primary care: future landscape

1. *Consistent levels of high quality performance*
2. *Robust patient and public engagement informing commissioning*
3. *Comprehensive range of services provided in primary care settings including a wide range of diagnostic tests and treatments*
4. *Services are available at times and places that are convenient to patients and appropriate to need*
5. *The highest risk patients identified and patient-focussed pathways put in place*
6. *Premises of consistent quality and meeting minimum standards*
7. *Sustainable provider landscape with services delivered at-scale*

Key challenges

- *Large geographical footprint with many contractors.*
- *Legacy of predecessor organisations and the history and relationships forged with contractor groups*
- *Nationally negotiated contracts leave limited scope for savings.*
- *Large number of small practices*
- *Significant number of elderly sole practitioner contractors.*

Improvements

- *Driving up quality by reducing variation and tackling unacceptable levels of service*
- *Improved access to GP services*
- *Wider range of services provided in community pharmacy and general; practice*
- *Increases in flu vaccination coverage*
- *Improvement in the prevalence of depression compared to estimated model*
- *Post payment verification and audit activities*
- *Review of discretionary payments*

ATTACHMENT 12: 2015/16 PRIMARY CARE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

NHS England

Priorities for 2015-17
Strategy ▪ Work with CCGs in the co-commissioning of primary care services ▪ Work with CCGs in the development of local Primary Care Strategies to reflect national priorities ▪ Work with CCGs in developing local Primary Care Estates Strategies to support improved access and the provision of primary Care at scale including new models of care
Quality ▪ Implementation of the quality improvement strategy for primary care ▪ Implementation of the web based tool for GP quality indicators has been developed and adopted locally ▪ Work with the central team to develop the performance assessment frameworks for each provider group ▪ Work with the central team to develop further a robust reporting system is in place for reporting quality concerns SUIs, never events in primary care ▪ Ensure Safeguarding systems are embedded in primary care and there is evidence they are operating across all independent contractor groups ▪ Ensure there is demonstrable evidence of improved patient satisfaction of primary care services ▪ Working with CQC in relation to the inspection of independent contractors and support for failing practices
General Practice ▪ Continue with implementation of the Single Operating Model across all provider groups ▪ Continue to work with CCG and CSU to develop SCR into patient accessible electronic record ▪ Work with practices to roll out online services, such as access to appointments , prescribing and e.consultations ▪ Continue implementation of equalisation of contracts ▪ Implement 7 day working in General Practice as part of the Primary Care Strategy ▪ PMS – Align PMS contracts with local emerging Primary Care Strategy to achieve better outcomes and value for money ▪ APMS – Align APMS contracts with local emerging Primary Care Strategy to achieve better outcome and value for money

ATTACHMENT 12: 2015/16 PRIMARY CARE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

- Align premises development plan with emerging Primary Care Strategy
- Implementation of changes agreed as part of the annual contract negotiations (see next slide)
- Work with CCGs to ensure that a comprehensive premises development plan is developed to assist investment and planning

Dental Services

- Work with central team on the development of the Assurance management framework for Dental services
- Further embed the single operating model for dental services
- Prepare for the implementation of the new Dental Contract
- Fully operational LPNs in place
- Ensure contracts are in place with acute providers for secondary and community care dentistry
- Implement specialty pathways for dental as they are developed
- Implement the Assurance Management Framework for Primary care dentistry
- Review of care pathways to decrease the number of referrals into secondary care
- Review case mix in specialised services and develop new pathways
- PDS – rationalise and align KPIs with local priorities
- Contribute to national Orthodontic review – resulting in extension of contracts or procurement
- Ensure robust OOH /7 day service is in place
- Promote access to dentistry ensuring rate of new patient relates to need

Community Pharmacy

- Ensure the revised Control of Entry regulations adopted by AT and operational
- EPS programme being developed through CCG /CSU
- Established LPN in place for Pharmacy and Optometry
- Development of the Pharmacy needs assessment working with Local Authority

ATTACHMENT 12: 2015/16 PRIMARY CARE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

Optical services

- **Work with the central team on the development of the assurance management framework for Optical services**
- **Further embed the single operating model for Optical services**

Family Health Services

- **National re negotiation of the FHS / SBS Contracts**
- **Ensure contracted out FHS service meeting all quality, service and financial KPIs**

Other services

- **Work with the central team to develop the Single Operating for translation and interpretation services**
- **Work with the central team to develop the single Operating model for Occupational Health services**
- **Contribute to National review of clinical waste and prepare for tender in 2015/16 – new service in place 2016/17**

ATTACHMENT 11: 2015/16 PRESCRIBED SPECIALISED SERVICES SUMMARY PLAN

Values and	Services are patient centred	Improved outcomes are delivered	Fairness and Consistency – patients have access to	Productivity and
Domains	Prevent premature death	Quality of life for	Help recover from ill	Ensure positive	Care delivered in a safe

Pre-existing Priorities	Strategic Context and Challenges	QIPP Improvements	Organisational Development
Implementation of Safe and Sustainable Paediatric Cardiac and Paediatric Neurosurgery Services through Network implementation Supporting the PCT/Cancer Network legacy planning and provision of radiotherapy capacity Reviewing equipment replacement/modernisation to improve access for patients and to improve outcomes for patients Continue to implement the review of vascular services to ensure compliance with national standards Continue to support the development of Neonatal Services in line with DH toolkit and national metrics and products	Implementation of single operating model for specialised commissioning underpinned by principles of 5 Year Forward View and Collaborative Commissioning All specialised activity covered by one national contract with each provider based on 'place based' treatment, with 'place based' budget allocation National core specifications/clinical policies in place for all services or derogations applied for (provider derogation), or led by commissioners (Commissioner led derogation) Requirement to establish effective relationship with key partners, Clinical Reference Groups, CCGs, other Area Teams, Health & Wellbeing Boards, OSCs, providers, Strategic Clinical Networks, ODNs, PHE, PPV and clinical senate	Review and adoption of national and local QIPP/Productivity and Efficiency schemes to meet circa £14-17m challenge National process for review and procurement of excluded drugs and devices Implementation of nationally agreed clinical access policies and commissioning through evaluation Review national service specifications and quality dashboards to identify areas for improvement in conjunction with NPoCs Support clinical and patient engagement to deliver implementation, working in partnership with SCNs, ODNs to support	Integration of specialised services function into the new structure for specialised commissioning as a regional structure with close working relationships with the local NHS England office with specific regard to quality, and whole system management Continue to prioritise the development of contract management skills and expertise within the team Support development of matrix working and networking of teams across the South landscape Lead the team to work to NHS England vison & values Support provider engagement to embed new operating model and clinical engagement

ATTACHMENT 11: 2015/16 PRESCRIBED SPECIALISED SERVICES SUMMARY PLAN

NHS England

By Programme of Care (PoC)	South East Priorities 2015-16 • **Implementation of national service specifications** • **Adherence to National Clinical Policies and Circular Guidance** • **Benchmark local prices to ensure efficiency and productivity** • **Delivery of QIPP schemes to support Commissioning Strategy**	Expected Outcomes in 15-16	End State Ambition
Internal Medicine	• Deliver compliance of KSS vascular surgery services to national service specification • Implementation of recommendations of SCN review of interventional cardiology, through 15-16 contracts	• Vascular services to meet national specification • Achievement of core clinical and quality requirements	• All services compliant with national standards to achieve improved outcomes • Safe and sustainable services with clear patient pathways and improved outcomes
Cancer and Blood **N.B. this will be split into 2 separate**	• IOG /Service Specification/QIPP compliance for cancer and radiotherapy services • Review of Urological cancer services, Kent, Surrey & Sussex	• Implementation of locally agreed plans to improve access to radiotherapy, seek to resolve Sussex issues on expansion/modernisation of linacs	• Improved access to radiotherapy • Consistent national tariffs in place • Patients to receive optimum care • consistent and equitable provision of

PoC	• Implement long term strategy for Oesophageal Cancer Surgery for K&M • Cancer Drugs Fund – support Wessex with implementing national process and policies • HIV/AIDs - Identify activity and money for the current integrated outpatient services. Work with local authorities to identify HIV costs and ensure there are contractual arrangements that ensures patient experience doesn't suffer and these services remain integrated	• Reduction in differential pricing and variations in service • Development of cancer services and designation of providers in line with national clinical policies and service specifications/ IOGs • Compliance with cancer drug fund guidelines • Implementation of Blue Teq to support good clinical practice with high cost chemotherapy drugs	chemotherapy and cancer drugs
Trauma	• Sussex Major Trauma centre compliance of neurosurgery support delivered through derogation • Implement the designated burns facility model and review the implications of the national service specification for local provider • Provider specialised T&O & spinal	• MTC to be fully compliant with national standards and quality requirements • London and SE consensus on the configuration of burns services • Achievement of national standards and improved waiting times • Functioning ODN in delivery of	• Burn care services compliant with the national model • Safe and sustainable spinal surgery services • Improved access to spinal surgery and care pathway management

	surgery review to understand provision & need • Work with Operational Delivery Network (ODN) on adult critical care delivery of QIPP and resilience	specialised adult critical care compliant and efficient services	
Women and Children	• Work with ODN on neonatal QIPP & review neonatal services against BAPM/Specification/national products • Implementation of networks for Children's Safe and Sustainable Cardiac and Neurosurgery • Work with CCGs on level 2 HDU provision and implications on PIC and pathways	• Functioning ODN in delivery of neonatal services that are compliant and efficient • Neonatal services to achieve national standards	• Improved network and pathway management • Safe and sustainable services • Neonatal retrieval services compliant with all national standards • Ensure PIC networks and retrieval are sustained with import to out of geography providers
Mental Health	• Specialised MH identified as a collaborative commissioning priority topic area with CCGs • Focus on CAMHS pathways, implementation of increased case manager support • Support review and procurement	• Continued focus on these areas to manage demand • Improved quality and consistency of services • Review of identified priority areas	• Case management in place for all specialised MH services • Compliant services • Improved access to and egress from secure services • Provision of high quality, clinically

	of low & medium secure services • Focus on Care and Treatment Reviews	• Local assessment of capacity • Provision of high quality, clinically safe services for people with LD	safe services for people with a LD

From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Interim Director of Public Health

To: Kent Health and Wellbeing Board

Date: 18th March 2015

Subject: Public Health Commissioning Intentions 2015/16

Classification: Unrestricted

Summary:

Across Kent, Public Health has a key role to play in delivering the outcomes of the Joint Kent Health and Wellbeing Strategy. Nationally the NHS Five Year Forward view identifies the need to radically increase the role of prevention across the system and new responsibilities in The Care Act clearly show that effective prevention is key.

Over the last 12 months, through learning and engagement in Health and Well-being boards, a series of procurements, and also through contract monitoring the inherited public health services, there is a much fuller understanding of the potential and the limitations of the current service design. There are clear opportunities for a new and more integrated approach.

Based on this learning, Public health will agree, in partnership, a new strategic delivery plan for Public health across Kent including a commissioning strategy. This will ensure that future public health services will be based around the needs of the person as a whole, and wherever possible interventions are within integrated services, shaped through integrated commissioning. Examples such as the transfer of the Health Visiting service into KCC offer real opportunities to ensure strong connection between Health Primary Care services and KCC Early help services.

Whilst this strategic review and work takes place, key commissioning intentions will continue in partnership, detailed in this report, and structured into a Starting Well, Living Well and Ageing Well approach.

2015/16 is a year in which a new approach to public health must be accelerated. We must move away from standalone provision focused on one particular lifestyle issue, and focus on shared outcomes, collectively addressing underlying causes of health inequalities across Kent.

1. Introduction

1.1. Nationally the importance of good prevention continues to be embedded in statutory and strategic guidance. The 5 Year Forward View and The Care Act set out a Call to Action and statutory framework or effective prevention.

1.2. During 2014/15 the KCC Public Health department have worked closely with colleagues across the Health and Wellbeing system in Kent, supporting prevention through the implementation of the Joint Health and Wellbeing Strategy. It has been a year of learning, analysing the resource available through the public health grant, drilling down into the performance of services and reviewing the effectiveness of different approaches. Some good progress has been made, there are improvements in performance, integrated models of care have been developed and efficiencies have been driven on key contracts. However, it is recognised that much of the approach is still based on outdated models of service, and that there are huge opportunities to improve the support and services available through the evolving integrated arrangements in health and social care.

1.3. In early 2015/16, a Public Health strategic delivery plan will be developed, and aligned to this will be a 3 year commissioning strategy. This will set out how public health services can be reconfigured to support the approaches identified in the Joint Kent Health and Wellbeing Strategy to maximum effect and accelerate the preventative work across Kent in the Health and Wellbeing system.

2. Background

3. Progress in 2014/15

3.1. During 2014/15 Public Health have been focussed on progress in key priorities identified in the Joint Kent Health and Wellbeing Strategy. Examples include the implementation of a breastfeeding support service (in support of Outcome 1, Priority 1), the procurement of a Postural Stability Service (in support of Outcome 3, Priorities 2 and 3), and the development of the Emotional Wellbeing strategy for children (in support of Outcome 1). A series of needs assessments have been developed and work on integrated intelligence continues in programmes such as The Year of Care.

3.2. There has been a focus on contract management resulting in more efficient contracts. Contractual relationships have developed with new organisations in the community and a number of new models of service have been tendered. Performance in programmes such as Health Checks has measurably improved, and for the first time in 4 years the service is on track to meet the target of 50% of invitees attending for their check. The improvement in activity is matched with reduced spend, the activity based contracting approach used has delivered both efficiencies and improved performance.

3.3. During the development of new services, the commissioning team have worked to engage with the voluntary, community and social enterprise in particular for some of the smaller scale community based interventions. A Dynamic Purchasing System (DPS) for Public Health services has been established and by January 2015, 22 different organisations were accepted onto the DPS. 63% were Kent-based organisations.

3.4. Community Sexual Health Services have been re-tendered. The process has provided a number of challenges and learning for implementing new models of care. The model delivers some key improvements. Based on a hub and spoke model it is significantly more efficient. Capacity has been realigned with where the need for service is. And it has been jointly commissioned with NHS England to ensure the right approach with services for those who need HIV services.

4. Commissioning Intentions for 2015/16

4.1. It is intended that 2015/16 is one of development and change for the services commissioned by Public Health. The opportunity presented by the transfer of Health

Visitors into the local authority, alongside the coming to an end of the majority of the major contracts for many of adult healthy lifestyle services will allow for the application of the strategic principles of the Health and Wellbeing Board to reshape service design and commissioning.

4.2. A new model for core public health services will be driven through the development of a Public Health strategy and commissioning plan. This will fully assess the opportunities for alignment with the transformation agenda's across partners of the Health and Wellbeing Board

4.3. During this time, there will be continued rigorous contract management in commissioned services, ensuring that they deliver the outcomes specified and further efficiencies are driven, whilst we undertake the redesign of services in partnership.. In addition there will be a series of engagement events with community organisations and employers to re shape our approach.

4.4. The Public Health strategic delivery plan will be structured into 3 areas for improved outcomes.

5. Starting Well

5.1. In October, Public Health will inherit the commissioning of Health Visiting from NHS England. During the past months collaboration between the commissioners and providers has been growing to ensure that a smooth transition takes place. A particular focus of this work has been assessing progress that is being made to meet the workforce baseline and the quality of the current provision.

5.2. KCC decided not to simply transfer the existing NHS England contract, but to have a new contract from October 2015. This will allow time to build a new model for provision in partnership, in particular with General Practice and Early Help services.

5.3. The transfer will also include the Family Nurse Partnership, a service that is widely valued for young parents who welcome additional intensive support for developing their parenting skills. There are opportunities to link in KCC provision for example employment skills support into this provision and to share learning about the approach between similar services, such as the Troubled Families programme.

5.4. As part of every programme of work there must be a clear focus on Healthy weight in children. Increasing obesity in children is being recognised not just as a timebomb for demand on a range of health services, but also as a key underlying issue affecting emotional wellbeing. The response to this issue cannot be confined to the public health team. It is a whole system challenge requiring collaboration with education, health and social care colleagues but most importantly with families themselves.

5.5. Work will continue on the two priority Public Health areas identified by Outcome 1, Priority 1 of the Joint Health and Wellbeing Strategy, namely increasing breastfeeding rates, and the reduction of smoking in pregnancy. The breastfeeding support service (supplied by PS Breastfeeding) has been implemented, whilst interventions such as Baby Clear, are being closely monitored and will be supported by a social marketing campaign.

5.6. The Public Health team will also continue to work in partnership in the development of the Emotional Health and Wellbeing Strategy for young people, ensuring delivery of the prevention and early intervention actions, whilst continuing to jointly commission the Young Healthy Minds service and the new model of provision within the whole

pathway of care.

6. Living Well

6.1. During 2015/16 we will engage in a whole system review of the service models to support people to live healthy lifestyles including the approach to healthy weight, physical inactivity and smoking cessation services. This will be a core programme driven through Local Health and Wellbeing Boards.

6.2. The current models for delivery in drug and alcohol services, also need to be refreshed,with the current contracts expiring at the end of March 2016. Opportunities such as the remodelling of healthy lifestyle services and the implementation of the sexual health services are key to reshaping more integrated provision.

6.3. During 2014/15 we have been working closely with colleagues from Social Care and Clinical Commissioning Groups to develop the Mental Health core offer of support, to be tendered during 2015/16. This is a priority programme and a leading example of a cross system approach. Public health is focused on both the promotion of wellbeing, and also effective early intervention within the model, a great opportunity to build effective prevention.

6.4. Health Checks delivery will continue to be managed closely to further increase performance towards the governments stretch target. The service has been improving its targeting of Health inequalities which we continue to closely monitor.

6.5. As set out in the 5 Year vision there is huge opportunity to focus on health within the Workplace. In Kent there is a Healthy Business award and will continue to sign up new businesses. There is much more that can be done, across Kent within partner employees. In addition. KCC have strong links with a range of employers across the County both in public and private sectors. This is a great opportunity to drive a population level impact.

7. Ageing Well

7.1. The focus on supporting people to age well will continue. The new postural stability services doubles capacity utilising the DPS described above. This is a key preventative agenda for both Health and Social Care and the impact on reducing falls and demand for specialist services will be closely monitored.

7.2. The Keep Warm Keep Well campaign and associated services, will help to support people to remain well, and in their own homes. Public health will continue to develop the relationship with NHS England Screening & Immunisation team, and will extend the Flu campaign that we developed in 2014/15.

7.3. We will be also begin the work with Social Care and health colleagues on the Older peoples core offer, particularly in relation to Social Isolation. This will mirror the approach in the Mental health core offer working with partners to review the outcomes that all want achieved and developing a range of services, connected with each other that older people can access, integrated with community provision.

8. Integrating the system, delivering better services

8.1. As outlined above, there is a huge opportunity over the coming twelve months to reshape how the Public Health services are delivered, and to ensure that we are achieving our outcomes.

8.2. The Public Health commissioning plan will take account of this changing landscape in order that the services are delivered in an integrated way, and as part of a seamless clinical pathway.

8.3. As part of this work is required to design and develop the most appropriate evaluation framework to determine impact of services using a whole system / whole population approach. This will be essential to understand the relative merits of different services being accessed by different population groups as well as estimating more robustly the combined economic benefits of PH commissioned programmes. This evaluation framework is expected to be designed, using the intelligence system created by the Kent & Medway Health Informatics Service that brings together person level linked NHS and non NHS datasets under the national Long Term Conditions Year Of Care programme.'

9. Conclusion

9.1. Public Health commissioning has been delivering on the outcomes identified in the Joint Health and Wellbeing Strategy, working in partnership across the health and social care system to shape services, and deliver outcomes for the people of Kent. The coming years present an opportunity, through new responsibilities, and through the expiration of contracts, to reshape the commissioning strategy and the resulting services to meet the challenges of a changing landscape, and the shifting needs of the population.

10. Contact Details

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From:	Roger Gough	Cabinet Member for Education and Health Reform
	Graham Gibbens	Cabinet Member for Adult Social Care and Public Health
	Andrew Scott-Clark	Interim Director of Public Health
To	Kent Health and Wellbeing Board	
Subject	Pharmaceutical Needs Assessment	
Classification	Unrestricted	

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1 Introduction

1.1 The Health and Social Care Act 2012 transferred responsibility for the Pharmaceutical Needs Assessment from Primary Care Trusts to the Health and Wellbeing Boards on the 1st April 2013.

1.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

1.3 Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up-to-date, a statement of the need for pharmaceutical services in its area, otherwise referred to as a Pharmaceutical Needs Assessment (PNA).

1.4 Each HWB is required to publish its own revised PNA for its area by 1st April 2015.

1.5 The main aim of the Kent Pharmaceutical Needs Assessment is to describe the current pharmaceutical services in Kent, systematically identify any gaps/unmet needs in consultation with stakeholders and make recommendations on assessed gaps and future developments.

The Pharmaceutical Needs Assessment is a key document used by NHS England and the local area Pharmaceutical Services Regulations Committee (PSRC) to make decisions on new applications for pharmacies and change of services or relocations by current pharmacies. It is also used by commissioners reviewing the health needs for services within their particular area, to identify if any of their services can be commissioned through pharmacies.

The Kent Pharmaceutical Needs Assessment consists of an overarching document explaining the details about pharmaceutical services and how needs are assessed, accompanied by a separate PNA document for each Clinical Commissioning Group area making recommendations for that area.

2. PNA Development

2.1 In November 2013, a paper was taken to the Health and Wellbeing Board seeking

agreement to set up a Steering Group to oversee the production, consultation and publication of the Pharmaceutical Needs Assessment. This was approved.

2.2 The steering group is made up representatives of key stakeholders as well as representatives of each of the Clinical Commissioning Groups.

2.3 A further paper was presented to the Kent Health and Wellbeing Board on 17th September 2014 seeking approval to formally consult on the draft PNA. The H&WB Board approved this.

3.0 Consultation

3.1 The County Council consulted with key stakeholders as defined in the regulation and as per KCC guidelines from the 5th November 2014 until 5th January 2014.

Key stakeholders were sent letters from the interim DPH inviting response to the consultation. Wider consultation was conducted through HealthWatch Kent, via the Kent County Council website and via CCG Patient Participation groups and local networks, and through various patient voluntary groups through HealthWatch Kent.

3.2 Publication of the PNA will include results of the consultation and relevant comments.

3.3 The PNA has been revised to reflect the consultation results where appropriate and recommendations for each individual area have been discussed in detail by the steering group and are documented in the CCG level PNAs.

4.0 Recommendations

4.1 Note the key strategic findings of recommendations of the PNA which are as follows:

- Overall there is good pharmaceutical service provision in the majority of Kent.
- Where the area is rural, there are enough dispensing practices to provide basic dispensing pharmaceutical services to the rural population.
- There are proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City. This will mean that these areas will need to be reviewed on a regular basis to identify any increases in pharmaceutical need.
- The proposed Paramount leisure site plans in North Kent should be reviewed regularly to identify whether visitors and staff will have increased health needs including pharmaceutical.
- The current provision of “standard 40 hour” pharmacies should be maintained especially in rural villages and areas such as Romney Marsh.
- The current provision of “100 hour” pharmacies should be maintained.

4.2 The Health and Wellbeing Board has the responsibility of publishing supplementary statements when the pharmaceutical need and services to an area change

significantly. It is proposed that these are issued every 6 months by NHS England (a member of the Board) as they hold all the relevant data. They will be published on the Council website alongside the PNA.
The Health and Wellbeing Board is asked to approve the process and timeframe.

4.3 The Health and Wellbeing Board is asked to approve the final PNA ready for publication subject to final checking with NHS England on any pharmaceutical service application grants made following the consultation and final tweaks through proofing and editing.

5. **Contact Details**

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By: Roger Gough, Cabinet Member for Education and Health Reform

Peter Oakford, Cabinet Member for Specialist Children's Services

Andrew Ireland, Corporate Director, Social Care Health and Wellbeing

To: Kent Health and Wellbeing Board

Date: 18 March 2015

Subject: **Revised protocol on the working arrangements between the Kent Health And Wellbeing Board, Kent Children's Health And Wellbeing Board and Kent Safeguarding Children Board**

Classification: **Unrestricted**

Summary

This paper provides further contextual information relating to the revised draft Protocol, which sets out on the working arrangements between the Kent Health and Wellbeing Board (HWB), Kent Children's Health and Wellbeing Board (CHWB) and Kent Safeguarding Children Board (KSCB).

Recommendation for Approval

The Board is asked to:

AGREE the revised draft Protocol, subject to the inclusion of any amendments or additions the Board deem necessary.

1. Introduction

1.1 This paper provides further contextual information relating to the revised draft Protocol (see Appendix 1), which sets out on the working arrangements between the Kent Health and Wellbeing Board (HWB), Kent Children's Health and Wellbeing Board (CHWB) and Kent Safeguarding Children Board (KSCB).

2. Background

2.1 The government guidance on inter-agency working to safeguard and promote the welfare of children, 'Working Together', was revised in March 2013. The modified guidance clarifies the legal responsibilities of all professionals (both individuals and organisations) in relation to the safeguarding of children, making it explicit that this is the responsibility of all practitioners who work with young people. 'Working Together' sets the expectation that collaborative inter-agency

work (especially between local authorities, Health and the police) is integral to delivering the best outcomes for children, and this relates to any actions taken and services provided to this end. This means partner agencies need to work in a collaborative and transparent way at every level in order to fulfil their statutory roles and responsibilities. In order to fulfil this requirement, is therefore essential that Kent's various memorandums of understanding set out the relationships between the structures which govern multi-agency activity and collaboration in this arena.

2.2 The Protocol that was previously in place related to working arrangements between the Joint Commissioning Board (JCB) and KSCB in relation to safeguarding and the promotion of wellbeing. Since the dissolution of the JCB and creation of the CHWB, which took over a number of the JCB's functions, no further amendments had been made to this document.

2.3 To add to this, the original Protocol did not cover the work of the HWB or map how the work of this body aligned with/tied into the work of the other multi-agency Boards.

2.4 The aim of the attached revised Protocol is to support all three partnerships to operate effectively, being clear about their respective functions; inter-relationships; and the roles and responsibilities of all those involved in promoting and maintaining the health and wellbeing of children and in keeping children safe. This is essential in order to maximise the effectiveness of safeguarding work, to avoid duplication and to ensure that there are no preventable strategic or operational gaps in safeguarding policies, services or practice.

Recommendation for Approval

The Board is asked to:

AGREE the revised draft Protocol, subject to the inclusion of any amendments or additions the Board deem necessary.

Appendix 1 - Revised Protocol on the Working Arrangements between the Kent Health and Wellbeing Board, Kent Children's Health and Wellbeing Board and Kent Safeguarding Children Board

Background Documents - Working Together to Safeguard Children, March 2013

Contact details

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PROTOCOL ON THE WORKING ARRANGEMENTS BETWWEN THE KENT HEALTH AND WELLBEING BOARD KENT CHILDREN'S AND WELLBEING BOARD AND KENT SAFEGUARDING CHILDREN BOARD

1. Purpose

1.1 This document sets out the working arrangements between the Kent Health and Wellbeing Board (HWB), Kent Children's Health and Wellbeing Board (CHWB) and Kent Safeguarding Children Board (KSCB).

1.2 The aim of this protocol is to support all three partnerships to operate effectively, being clear about their respective functions; inter-relationships; and the roles and responsibilities of all those involved in promoting and maintaining the health and wellbeing of children and in keeping children safe. This is essential in order to maximise the safeguarding of children and young people, to avoid the duplication of work and to ensure there are no preventable strategic or operational gaps in safeguarding policies, services or practice.

2. Principles and Functions

2.1 The HWB, CHWB and KSCB have distinctive and complementary roles in maintaining the health and wellbeing of children and keeping children safe. All three bodies exist as a result clear legal requirements: the HWB was established by virtue of section 194 of the Health and Social Care Act 2012; the CHWB was created under the provision of section 10 of the Children Act 2004 and the KSCB is a statutory partnership body created under the provision of section 11 of the Children Act 2004.

2.2 The Kent HWB provides leadership, ownership and directs on work to improve the health and wellbeing of all the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to secure better health and wellbeing outcomes across the county; to reduce health inequalities; and to ensure better quality of care for all patients and care users be they adults or children.

2.3 The CHWB works to promote cooperation between the local authority, relevant partners and other bodies working with children in order to improve the health and wellbeing of all children and young people in the local authority area. The Board advises and advocates on key policy and commissioning issues and makes recommendations for service integration and joint commissioning arrangements that address the needs of the most disadvantaged children. The Board reports into the Kent Health and Wellbeing Board.

2.4 The KSCB is responsible for ensuring that partner agencies with statutory responsibilities are appropriately safeguarding the children and young people of Kent and are actively promoting their welfare. The Board verifies that all responsible agencies are working together collectively in order to protect vulnerable

children/children at risk of abuse and neglect, and to make certain that the right resources are in place in order to meet their needs. The KSCB sets the performance, policy and strategic priorities for partnership working, and its membership comprises of senior representatives from all agencies responsible for child protection arrangements in the county.

3. Working Relationships

3.1 The HWB, CHWB and KSCB have a shared commitment to ensuring that safeguarding and the promotion of the welfare of children is a priority in Kent, being mindful of the importance of the child's voice in this process.

3.2 The Boards will have an ongoing and direct relationship, communicating regularly through identified channels/lead individuals, and will be open to constructive challenge in order to promote continuous improvement in safeguarding practice and outcomes.

3.3 The Boards commit to work together to ensure effective local partnership arrangements with the appropriate governance which are focused on contributing to protecting children from harm and on promoting their health and wellbeing.

3.4 In relation to respective roles and responsibilities:

The HWB will:

- Consider the totality of the resources in Kent for health and wellbeing and consider how and where investment in health improvement and prevention services could improve the health of children and young people, alongside the overall health and wellbeing of Kent's residents.
- Ensure that the CHWB and KSCB are formally consulted in relation to the Joint Strategic Needs Assessment (JSNA) and formulation of the Joint Health and Wellbeing Strategy (JHWS), specifically on issues which affect the welfare of vulnerable children/children at risk of abuse or neglect.
- Ensure that the advice and information provided by the CHWB and the KSCB is appropriately disseminated within the HWB member organisations and considered as part of the development of the JHWS.

3.5 The CHWB will:

- Provide a strong influence on children' health and wellbeing issues, advising and advocating on key policy and commissioning issues across the county in consultation with the KSCB.
- Deliver an informed and balanced report to the HWB annually (and at other reporting cycles agreed between them) on progress in relation to the health and wellbeing of children and young people in Kent. Make recommendations

for service integration and for joint commissioning arrangements that address the needs of the most disadvantaged children and young people, if required in collaboration with the KSCB.

- Offer expert advice to the HWB on the development of the JSNA (particularly relevant needs assessment), JHWS and appropriate commissioning plans with a focus on the health needs of children and young people.
- Take note of the recommendations and identified areas for improvement made by the KSCB in their annual report, and report back to the KSCB on subsequent progress.
- The Chair of the KSCB will be a member of the CHWB.

3.6 The KSCB will:

- Provide an annual report to the CHWB and HWB on local safeguarding arrangements and its findings relating to the monitoring/scrutiny of those arrangements.
- Contribute to the development and review of the children and young people's strategic plan, with a focus on safeguarding issues.
- Provide overarching safeguarding guidance and, if necessary, challenge in relation to the implementation of actions and outcomes for children.
- Influence and promote safeguarding within new service developments via agreed members with designated safeguarding responsibilities.
- Annually scrutinise plans and documents to ensure the safeguarding of children is appropriately addressed.
- Undertake specific work in relation to child protection priorities as agreed between Boards.
- Contribute to the development of local performance indicators in relation to child protection outcomes.

4. Evaluation and Review

4.1 If there are any areas of significant concern that cannot be resolved in accordance with this Protocol then a strategy meeting will be held between the Independent Chair of the KSCB, Chair of the CHWB, Chair of the HWB, the Director of Children's Services and any other senior person that is regarded as being required.

4.2 The HWB, CHWB and KSCB should review the implementation of this Protocol annually (in April), with variations discussed and agreed as appropriate by all three Boards.

Signatories

Approved on behalf of the Kent Health and Wellbeing Board

By: Roger Gough, Chairperson

Date: tbc

Approved on behalf of the Children's Health and Wellbeing Board

By: Andrew Ireland, Chairperson

Date: 03.02.15

Approved on behalf of the Kent Safeguarding Children Board

By: Gill Rigg, Chairperson

Date: 19.02.15

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Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **21st January 2015.**

Present:

Navin Kumta – Vice-Chairman in the Chair - Clinical Lead, Ashford CCG;

Tracy Kerly – Head of Communities and Housing, ABC;
Deborah Smith – Public Health, KCC;
Sheila Davison – Head of Health, Parking & Community Safety, ABC;
Neil Fisher – Head of Strategy and Planning, CCG;
Caroline Harris – HealthWatch Representative;
Martin Harvey – Patient Participation Representative (Lay Member for the CCG);
Tracy Dighton – Voluntary Sector Representative;
Amanda Godley – Ashford MHAG Co-Chair and SpeakUpCIC, Project Co-ordinator;
Mark Lemon – Policy and Strategic Relationships, KCC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;
Belinda King – Management Assistant, ABC;
Renu Sherchan – Environmental Health, ABC.

Also Present:

Councillor Britcher.

Apologies:

Cllr. Michael Claughton – Chairman – Cabinet Member, ABC;
Peter Oakford – Cabinet Member, KCC;
Philip Segurola – Social Services Lead, KCC;
Faiza Khan – Public Health, KCC;
Simon Perks – Accountable Officer, CCG;
John Bunnett – Chief Executive - ABC;
Christina Fuller – Cultural Projects Manager, ABC.

1 Declarations of Interest

Tracy Dighton made a Voluntary Announcement as she was employed by two 'not for profit' organisations, namely Ashford Counselling Service and SpeakUpCIC. She was also a Trustee for Case Kent.

Amanda Godley made a Voluntary Announcement as Co-Chair of Ashford MHAG and a SpeakUpCIC Project Co-ordinator.

2 Notes of the Meeting of the Board held on the 22nd October 2014

The Board agreed that the Notes were a correct record.

3 CCG Merger: Update

3.1 Navin Kumta advised that the merger was no longer taking place and this was despite successful presentations being made to a Panel in Tonbridge and discussions with patients and HealthWatch. The Panel saw no reason not to proceed with the merger however a letter had been received from NHS England stating that they believed that small CCG's offered better traction for achieving plans. Navin Kumta said that despite this the two CCG's were still looking at working closely together in order to reduce the risk which created the need to look into merger discussions in the first place.

The Board noted the update.

4 Focus on Mental Health – Mental Health Needs and Service Performance in Ashford

4.1 Circulated separately from the agenda was a copy of the PowerPoint presentation produced by Neil Fisher of the Clinical Commissioning Group. Neil Fisher gave the presentation, and set out below under the specific headings, answered questions raised by members of the Board. In introducing the presentation Neil Fisher explained that people with mental health problems died on average 20 years earlier than people with no mental health problems, with the principle cause of death being cardiovascular illness. He explained that his presentation included only specific information as it related to Ashford's profile, but he advised that the full 120 page document was available for viewing on the Public Health website.

Proportion of CCG Budget Spent on Mental Health Services

4.2 Tracy Dighton advised that she understood that the CCG spent in the region of 8.7% on mental health services, whereas the national average figure was 13%. Neil Fisher acknowledged that the need was greater than the current spend and that nationally it was recognised that mental health services were under-funded. Tracy Dighton further commented that studies showed that investment in mental health services helped to reduce and achieve savings in other areas of health provision. Sheila Davison referred to the data regarding emergency admissions for self-harm over 100,000 population that whilst not indicating a particular issue within Ashford it had been a subject of concern over the past year. Neil Fisher said that whilst the figure for Ashford on this particular issue was lower than the rest of England, there was a need to ensure that help was available, as principally if problems could be identified at an earlier stage it would address issues for later in that person's life. Sheila Davison said that she thought it was useful to map the trends of these indicators for the future and be aware of feedback from those working with young people.

4.3 In terms of the percentage of the population of Ashford with mental health diagnosis, Neil Fisher said this was slightly lower than the national picture. Furthermore nearly 90% of patients had a comprehensive care plan which he believed was a very good figure. In terms of the percentage of the patients

admitted as an in-patient Neil Fisher explained that the figures for Ashford were significantly lower in proportion than the rest of England and commented that the reasons for this could be because high standard community based services had reduced the need for admission. He acknowledged that some would comment that it was because Ashford did not have any mental health in-patient beds. On balance he considered that there was an element of both points in the shown figures.

4.4 Tracy Dighton said that she understood that 25 patients from the county occupied beds out of the area. Neil Fisher said that for the last two quarters in terms of Ashford's residents there had been no admittances outside of the Ashford area. He said they were predominantly to the north of Kent where the nearest hospital provision could be outside of the county.

4.5 With reference to the slides on patients on Care Programme Approach in settled accommodation, and patients on Care Programme Approach in employment, Neil Fisher considered that the figures reflected very well on the position as it related to Ashford. However the figures on patients on Care Planning were relatively poor.

4.6 Neil Fisher also explained that in terms of peer group comparators, the Ashford CCG was compared with ten others from around the country by NHS Right Care, and they looked at the pathways of care and what those pathways of care were looking to achieve.

Dementia Diagnosis

4.7 Neil Fisher explained that the overall target was 67.5% by the end of March 2015. However the CCG figures were in the region of 50%. The CCG were in regular contact with their General Practitioners about this and stressing that although there was limited treatment available for patients with dementia, there were social care provisions which would provide help. He believed that the work being undertaken would see an improvement in the overall figures by the end of March.

Strategic Aims – Focus for 15/16

4.8 Tracy Dighton asked whether care planning was reducing. Neil Fisher commented that NHS Right Care had said that Ashford could do better and that patients should all have a care plan upon discharge from hospital and for long-term conditions.

Mental Health Priorities

4.9 In terms of waiting times for people entering a course of treatment in Adult IAPT Services, Neil Fisher explained that at the present time there were no targets for children or young people but he believed that over time a target would probably be set.

General Questions arising from the Presentation

4.10 Mark Lemon commented that Government targets appeared to be skewed to acute treatment time. Neil Fisher said he agreed with the comment and new targets were being introduced on a regular basis and this was leading to changes in the system to enable those targets to be met.

4.11 Tracy Dighton asked what qualitative feedback the CCG received in terms of mental health service users. In terms of issues which affected Ashford, Neil Fisher stated that communication was sometimes raised as an issue by patients with service providers not always being unaware what services were available. He also said that he believed the correlation between health and social care was weak but believed that the community networks were improving this situation and that this Board was helping to improve the links between health and social care and other areas where there was an overlap between services. Although he accepted that concern had been expressed about the availability of beds in the area, he did not think that evidence supported this perception.

4.12 Caroline Harris said that HealthWatch was undertaking work with mental health providers which could be fed back to the Mental Health Groups. Neil Fisher also explained that he understood the Care Quality Commission was looking at the performance of the mental health service providers. Tracy Dighton suggested that the Chief Executive of Kent and Medway Partnership Trust be invited to a future meeting.

4.13 Amanda Godley had concerns over appropriate training for GP's in terms of mental health services. Neil Fisher explained that GP's had eight formal training sessions per year, one of which would have been on mental health. Additionally GP's could pick up on this area on a personal basis. The CCG was trying to emphasise what services existed to provide support for patients with mental health issues.

4.14 Tracy Dighton commented that the Voluntary Sector had no direct funding which could lead to some organisations ceasing to exist. She asked whether there would be a fund available to support such groups in the future. Navin Kumta explained that in his capacity as Chairman of the CCG that they were attempting to shift spend in the secondary sector to increase funding for the community networks. He explained that funding was stretched due to problems of demand at Accident and Emergency and said that if persons sought help from other available resources such as GP's or walk-in centres, then this would allow funds to be freed up to support funding for other sectors. Neil Fisher explained that Canterbury CCG had allocated £20,000 to help in terms of grants to the Voluntary Organisations and he commented that it would be helpful if this issue was vocalised within the community and in particular that expenditure on Accident and Emergency resulted in there being less funds available to spend on other health services. Navin Kumta suggested that the Better Care Fund could be another avenue to be explored in terms of support. Mark Lemon believed that the Board's discussion on this particular issue would be helpful. Neil Fisher agreed to give a similar

presentation for the voluntary sector to address the issues raised including Better Care Fund.

4.15 In conclusion Navin Kumta thanked Neil Fisher for the presentation which all had found very useful and said that he believed that Mental Health should be covered by future Lead Officer Group reports in order to keep the Board updated about developments. Mental health would also be subject to further consideration at subsequent meetings held in January of the Board. He said he would support the invitation of mental health providers to attend that meeting. These recommendations were supported by the Board.

5 Lead Officer Group (LOG) Quarterly Report

5.1 The report provided an update of the work which had been progressing since the previous meeting held on the 22nd October 2014 and set out a series of recommendations for consideration by the Board.

5.2 Sheila Davision referred to the draft Local Performance Progress Plan which had been circulated separately from the main Agenda. KCC Public Health had been leading on gathering the information for the Plan and work was still in progress.

5.3 In terms of individual projects Sheila Davison referred to the initiative on rough sleeping and advised that Ashford Borough Council had identified a budget of £20,000 towards the cost of a scheme in conjunction with Porchlight. The need for additional funding was highlighted.

5.4 With reference to the Infrastructure Working Group, Neil Fisher said that in relation to Ivy Court, Tenterden he had attended a meeting that week and said that there was a need for options to be developed as it was apparent that there was a need to make available more health provision from those premises. He had met with NHS England and Property Services to take this forward with a view to a further meeting being held on the 5th February 2015.

5.5 The report advised that the Kent Board had adopted the Kent Alcohol Strategy 2014-16 and that the LOG would consider this in February to assess whether there was a need for additional priority action for Ashford. Neil Fisher explained that brewers themselves had a legal obligation in terms of drink awareness but this also related to wider areas such as the availability of alcohol and the operation of pubs and clubs. Sheila Davison said she believed that there were two aspects to this issue. Firstly the health and wellbeing issue and secondly community safety. She explained that at the present time the Kent Alcohol Strategy was not a priority of the Ashford Health and Wellbeing Board but felt that in due course this would need to be considered. She said that the issue was a priority under the Community Safety Agenda falling within substance misuse.

5.6 For future reports Navin Kumta asked that the names of the officers on the LOG be included within the report.

The Board agreed that:

(i) the emerging draft Local Performance Progress Plan (LPPP) (circulated separately from the Agenda) be used as a robust framework to identify and evidence the local response to the Joint Kent Health and Wellbeing Board.

(ii) information be inputted to the LPPP and work on presenting ideas for joint promotion be considered by the Board in April together with the Chairman's formal report.

(iii) it be noted that Ashford Borough Council had identified a budget of £20,000 towards the cost of a Rough Sleeping initiative from April 2015 and partners be invited to consider any financial support they can provide to meet the shortfall of £14,155.

(iv) the Project Updates and that further work on project outcomes be required to collorate with the Kent Joint Health and Wellbeing Strategy, be noted.

(v) the Lead Officer Group to consider the request for funding to support the Rough Sleeping Project as referred to in Recommendation (iii) above.

(vi) the Kent Board's adoption of the Kent Alcohol Strategy and work required to identify priority local delivery be noted.

(vii) the progress for developing the new Homelessness Strategy be noted and consideration be given to the potential and the need for closer joint working in the future to address areas of common concern.

6 Partner Updates

6.1 Included with the Agenda were A4 templates submitted by Partners

(a) **Clinical Commissioning Group (CCG)**

Noted.

(b) **Kent County Council (Social Services)**

Noted.

(c) **Kent County Council (Public Health)**

Deborah Smith referred to recent data which showed an increase in smoking prevalence in Ashford. The Board was supportive of the need to consider this particular issue further.

(d) **Ashford Borough Council**

Tracey Kerly advised that a bid had been made to DWP for funding from the Flexible Support Fund to help those with mental health problems. Furthermore the new Welfare HUB was now available to provide assistance.

(e) **Ashford Children's Health & Wellbeing Board**

Noted.

(f) **Case Kent/Voluntary Sector Representative**

Tracy Dighton drew attention to the difficulties encountered by small voluntary groups in accessing funding via the Kent Business Portal due to the complex nature of the process.

Deborah Smith explained that a new commissioning system would be introduced which although it required certain steps to be followed, it was a lot simpler than the current system. She agreed to ask a colleague to send details of this system to Tracy Dighton and also said that she saw no reason why an officer who handled those grants could not attend a network meeting with the Voluntary Sector to explain how the process worked.

(g) **HealthWatch Kent**

Caroline Harris explained that HealthWatch had carried out a review of visits to the William Harvey A&E and Outpatients and would review them again in the Spring. Navin Kumta considered that the HealthWatch perspective should be reflected within the Action Plan.

Tracey Dighton explained that she had suggested that the Voluntary Sector be invited to give a presentation at a future LOG meeting with a view to them becoming more involved in the process.

7 Forward Plan

7.1 The Board noted the Forward Plan for subsequent meetings of the Board.

8 Next Meeting and Dates for 2015

8.1 Keith Fearon advised that the next meeting on the 22nd April 2015 would provisionally be held at Chamberlain Manor, Drovers Roundabout, Ashford subject to the satisfactory completion of the development. He indicated that he would let Members of the Board know in due course when the position was cleared.

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CANTERBURY CITY COUNCIL

CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD

Minutes of a meeting held on Tuesday, 27th January, 2015
at 6.00 pm in the The Guildhall, Westgate, Canterbury

Present: Dr Mark Jones (Chairman)

Faiza Khan
Councillor S Chandler
Velia Coffey
Amber Christou
Neil Fisher
Mr Gibbens
Councillor Gilbey
Councillor Howes
Steve Inett
Mark Lemon
Paula Parker
Councillor Cllr Pugh
Sari Sirkia-Weaver
Anne Tidmarsh
Mark Kilbey
Jayne Faulkner
Debbie Smith
Hilary Clayton
Richard Davis (Item 3)
Peter Marsh (Item 4)

1 APOLOGIES FOR ABSENCE
Cllr Watkins
Jonathan Sexton
Simon Perks
Cllr Andrew Bowles

2 MINUTES OF THE MEETING HELD ON 25 NOVEMBER 2014 AND ACTIONS
The minutes were approved as an accurate record.
All actions were complete.

Mark Jones reported that a letter was sent to Andrew Ireland regarding concerns over the changes to the Common Assessment Framework and that a response had been recently received.
Action: Response to this letter to be circulated to the Board.

3 UPDATE FROM PILGRIMS HOSPICES - RICHARD DAVIS
Richard Davis advised that the Hospice is continuing to provide a service as before and inpatient units are open in Canterbury, Thanet and Ashford as well as other outreach services. A new Chief Executive has recently been appointed and starts on 9 February 2015. The Trustee body is being expanded and the Board are considering the new 3 year strategy. It was noted that the deficit is covered by reserves for 24 months.

A query was raised regarding how work within the community was to be expanded and Richard Davis advised that this would depend on resources.

It was noted that key stakeholders will be involved in all future developments and it was agreed that the Canterbury and Coastal Health and Wellbeing Board (HWB) would be kept informed.

4 DEMENTIA FRIENDLY COMMUNITIES - PETER MARSH

Peter Marsh reported success had been achieved across parts of east Kent and they are now hoping to expand in the Canterbury area. He gave a presentation on the work they are doing to help people live well with dementia within the community.

A newsletter will be published twice a year and a website is also available. It is hoped that the projects will gain momentum through the Canterbury area. Velia Coffey stressed that Canterbury City Council are very keen to be involved and keen to seek ways to involve the rural communities as well as the city. It was agreed that the alliances are community led and are designed to specifically meet the needs of the local community.

Cllr Pugh commented that he had attended a meeting in Swale but had received no further information. It was advised that Sittingbourne and Sheppey groups are still very active and meet regularly and local schools are very involved.

Steve Inett commented that differences in the health resources available can influence the success of the alliances in different parts of the county. Peter Marsh commented that the project is funded by the Clinical Commissioning Group (CCG) and match funded by Kent County Council (KCC) but there is still a need to get GP practices on board and ensure that services are appropriate to the needs of dementia patients. The Community Trust, Mental Health Trust and the three Acute trusts are all involved in the alliance and there is a focus on partnership working.

It was reported that dementia care is a key part of the Community Networks so there is a need to link with the alliances to provide a multi agency solution making it easy for people to access the services they need within their community.

5 MENTAL HEALTH SERVICE UPDATE - NEIL FISHER

Neil Fisher gave an overview of the mental health needs in the area and the service provided and gave comparators both nationally and locally.

The presentation is attached.

The following was noted:

- The amount of money spent by the CCG per head on mental health services is average compared to England as a whole.
- Levels of diagnosis in the area are lower than expected but this may mean that there are more undiagnosed cases rather than less need.
- One of the key aspects of care is the Care Programme approach as this gives the best outcomes for patients. The number of people who have (or are aware they have) a Care Programme in Kent is low.
- Access to a primary care counselling service is poor in the CCG area.
- Waiting time standards are now in place for mental health patients for primary care counselling and crisis care.
- Mental health has been highlighted as a top priority within the strategic aims of the CCG.

- Concern was raised that there a little evidence of preventative measures or early treatment for mental health patients which could prevent the need for further treatment. New standards are being set and it is thought that this will become a focus following the general election.
- Dementia diagnosis, whilst the best in Kent, is still not meeting the targets. It is hoped that the target of 67% diagnosis will be met by March 2015 and the CCG is only 1 of 2 areas expected to reach this target.
- Access and referral is reported by service users to be poor. Kent and Medway NHS and Social Care Partnership Trust (KMPT) are commissioned for crisis care but it was acknowledged that more use could be made of community groups such as those supporting the homeless and vulnerable.
- Carers report that there is a lack of opportunity to engage with services.
- A half day workshop on care planning is due to be held and KMPT will be involved.
- No Canterbury patients have been placed out of area.
- A query was raised on how mental health issues are being addressed in areas of higher deprivation. This is being done by Public Health Commissioning.
  Action: Faiza Khan to circulate information on how mental health issues are being addressed in areas of high deprivation.

- The incidence of mental health problems is higher in social housing where it often contributes to people losing their home. Care Programmes are really important in helping to address this.

6 CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICE UPDATE - NEIL FISHER

Neil Fisher reported that there is a focus on the children's and adolescent mental health service (CAMHS) and wait times for assessment and urgent assessment are being reviewed. The Health Overview and Scrutiny Committee have also been focusing on this.

Weekly reporting was put in place in mid 2014 and they are now meeting the minimum standards for 4 week wait for assessment. Treatment time is currently 13 weeks.

Sari Sirkia Weaver reported that she and Suzi Wakeham met with four representatives from CAMHS to talk about various issues including waiting times and referrals. It was acknowledged that there are gaps in provision especially for those people with lower level problems. CAMHS will organise a joint training session with stakeholders to improve communications and a newsletter will be distributed. A representative from CAMHS will also join the Children's Operational Group and this was seen as a very positive step forward.

The transition from CAMHS to adult mental health services was raised as a concern and it was noted that there is group focussing on this.

It was suggested that CAMHS were asked if they perceive there to be a problem with transition.

It was agreed that, in future, this item will form part of the Children's Operational Group update.

7 ALCOHOL STRATEGY LOCAL RESPONSE - VELIA COFFEY

Velia Coffey presented the report as an audit of what is expected of Canterbury City Council and what is being done already. The alcohol strategy will be included in the strategic plan and will be used to address the local issues.

8 INTEGRATED COMMISSIONING GROUP UPDATE - PAULA PARKER

Paula Parker presented the report.

Action: A report on the work on falls to be brought to a future meeting.

It was noted that excellent planning for winter and a multi agency response has meant that east Kent has performed the best across Kent and Medway with no breaches of the 12 emergency standards and no black events.

9 LOCAL RESPONSE TO HEALTH AND WELLBEING STRATEGY - FAIZA KHAN

Faiza Khan reported that the action plan was submitted in September 2014 and in May 2015 will be reviewed against the outcomes. It was suggested that 4 or 5 measures are prioritised by the Core Group and reported to the next HWB meeting and also to the CCG Board.

Action: 4 or 5 measures to be prioritised by the HWB Core Group and reported to the next Board meeting.

9.1 Use of Joint Strategic Needs Assessment

Faiza Khan advised that feedback was being sought on how the JSNA has been used, how often it has been referred to in commissioning discussions and plans and how useful it has been.

A more detailed local needs assessment is being worked on for Ashford and one for Canterbury and it is hoped this will be available in the next few weeks.

10 CHILDREN'S OPERATIONAL GROUP REPORT

Sari Sirkia Weaver presented the report.

It was noted that the health visiting service will move to KCC and a query was raised as to whether they will continue to employ specialised health visitors. Faiza Khan offered to investigate this further.

Concern was raised that there is currently no mechanism for information or good practice to be shared with other Children's Health and Wellbeing Boards or with the Kent Children's Health and Wellbeing Board. There is no governance structure or national or county steer and the Board asked Mark Jones to raise this as a concern at the Kent Health and Wellbeing Board meeting. It was suggested that a workshop was held involving all key stakeholders.

Action: Mark Jones to raise concern at the Kent Health and Wellbeing Board regarding governance and information sharing between Children's Health and Wellbeing Boards at both local and county level.

11 ANY OTHER BUSINESS

None.

12 DATE OF NEXT MEETING

25 March 18.00 Guildhall Canterbury

DARTFORD BOROUGH COUNCIL

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

MINUTES of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on Wednesday 17 December 2014.

Present:

Councillor Roger Gough – Kent County Council (Chairman)
Councillor Ann Allen – Dartford Brough Council
Councillor Jane Cribbons – Gravesham Borough Council
Councillor Tony Searles - Sevenoaks District Council & Swanley Town Council

Sheri Green	Dartford Borough Council
Anna Card	Dartford Borough Council
Sarah Kilkie	Gravesham Borough Council
Tristan Godfrey	Kent County Council
Terry Hall	Kent County Council
Vicky Wiltshire	Kent County Council
Sue Xavier	Kent County Council
Debbie Stock	Clinical Commissioning Group
Dr Elizabeth Lunt	Clinical Commissioning Group
Cecilia Yardley	Healthwatch
Lee Rose	Kent Fire and Rescue Service

40. APOLOGIES FOR ABSENCE

An apology for absence was submitted on behalf of Andrew Scott-Clark. Terry Hall attended the meeting on his behalf.

41. DECLARATIONS OF INTEREST

There were no declarations of interests.

42. URGENT ITEMS

There were no urgent items.

43. THE MINUTES OF THE MEETING OF THE DARTFORD, GRAVESHAM, AND SWANLEY HEALTH AND WELLBEING BOARD HELD ON 29 OCTOBER 2014.

The minutes of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on 29 October 2014 were agreed as an accurate record. There were no matters arising.

44. THE MINUTES OF THE MEETING OF THE KENT HEALTH AND WELLBEING BOARD HELD ON 19 NOVEMBER 2014.

The Chairman summarised the meeting of the Kent Health and Wellbeing Board held on 19 November 2014. He drew attention to a communication from Jeremy Hunt to all Health and Wellbeing Boards about what relationship they should have with providers. The Chairman explained that a view had been taken to restrict the membership of local boards to commissioners as the membership of the boards was already quite large, there were other channels for communicating with providers and Kent was in the vanguard in terms of good commissioner-provider communications.
The Kent Board had received a presentation from Frank Gibbons on progress with delivering the outcomes in the Joint Health and Social Care Self-Assessment Framework for 2013-14. In terms of Winterbourne View there had already been an assessment which focussed on dealing with the needs of service users rather than meeting framework targets.

The main changes introduced by the Care Act 2014 were discussed and the greater needs of Care Workers had been noted and Healthwatch would be making a presentation to the next Board meeting in January.

Resilience issues across Kent had been discussed although it was noted that DGS was better placed than most other areas in Kent, notably Medway, as a result of recent improvements. The minutes of the Local Health and Wellbeing Boards had been noted along with the minutes of the Children's Health and Wellbeing Board and the Emotional Health and Wellbeing Strategy had been discussed.

The DGS Health and Wellbeing Board discussed the current commissioner-provider split and noted that this was complex and imperfect for example Districts were providers in respect of their public health commissioned responsibilities and the County Council in respect of social care. The implications of the Care Act for districts was discussed, particularly housing and environmental health teams. Health staff also found that when Council officers identified customers in this way they were tending to be referred to acute hospital care rather than towards primary care providers or contacts in the voluntary sector who would often be more appropriate points of contact. It was felt that there should be a single route to ensure that referrals were channelled to the practitioners who were best positioned to assist and noted that the voluntary sector often felt frustrated at their lack of direct involvement at an early stage. Some work had already been carried out with the Chairman of the West Kent CCG to undertake a pilot with the voluntary sector whereby referrals would be channelled.

The Chairman felt that the Kent Health and Wellbeing Board would be very interested in examining how District Council's related to the Care Act and to how health and Council practitioners worked with local community agencies. The Board had also been told that Emma Hanson had recently given a presentation on this topic and it was agreed that this should be a future agenda item and that Emma should be invited to deliver her presentation.

45. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS

The Board received and noted a position statement on actions arising from previous Board meetings. In terms of the inclusion of health needs in future s106 and CIL agreements the Chairman reported that he had raised this with KCC Planning and that this would be an item on the Kent Board agenda in January.

46. KENT FIRE AND RESCUE SERVICE

The Board received a presentation by Lee Rose, Head of Community Safety for the Kent Fire and Rescue Service (KFRS), on the work that the KFRS undertakes and the greater opportunities for KFRS to work with health and community personnel and bodies.

Mr Rose was keen to stress that the KFRS did much more than deal with fires and that there were many services that could be offered to assist other agencies. A key focus was upon prevention and this had seen a reduction in the number of fire related call-outs of 70-80% in the last decade but greater involvement with road traffic collisions and specialist rescue.

The focus on prevention meant that KFRS had developed expertise in identifying people at risk. A lot of work had been done on identifying and working with vulnerable people including young and old people, the disabled, people with mental illnesses, dementia, those at risk of domestic violence, child safety and fire-setters. This had involved working with many agencies, the police, social services, schools, prison and probation services, local authorities, voluntary services and health agencies. KFRS offered training services for dealing with people suffering from dementia and were seen as national leaders in this field, they regularly attended one-stop shops in connection with domestic violence, they had a nationally recognised programme for dealing with fire-setters and visited schools and businesses where they could offer advice on prevention and also business continuity. Fire stations also housed other services and many of the 66 stations across Kent were shared with other agencies such as the police. Key areas were working with vulnerable people, dealing with slips, trips and falls to prevent admissions to hospitals, work with the business community and programmes such as “Firefit” which assisted in tackling issues such as obesity, elder fitness and youth engagement.

Fire Officers were often the first point of contact with people most in need of accessing health and social care as they were seen as readily identifiable and trustworthy. People would often allow fire officers into their homes when they would not allow access to other people. This meant that Fire Officers were uniquely placed to be able to alert other agencies over the needs of individuals who might otherwise not be known to them and it made sense for agencies to tap into their expertise and accessibility as they shared the same customers and for agencies to use the “Fire brand”. In order to do so it was

important to identify how to integrate services, and to remove blockages to this to sieze the wider opportunities available.

The Board discussed how KFRS staff made their referrals and followed up contacts to access the right care path for each customer. It was explained that officers had been trained and also had specific risk criteria which would be applied in each case to categorise the customer and how best to meet their needs. These were directly correlated with, and linked, to specific services. In addition to these reactive interventions the Fire Service also carried out commissioned work whereby it would be asked to undertake particular visits or tasks. An example of this was the 10,000 home safety visits carried out across Kent each year. KFRS conducted 150 such visits per week and ideally would wish to target these on the most vulnerable and at risk-people which greater sharing of information across agencies could assist. The relationship of KFRS and CAMHS was discussed and it was explained that the the two services worked closely together. All of the KFRS's cars now carried defibrillators and were often the first responder. Whereas there were 34,000 ambulance staff dealing with 9.3 million calls nationally there were 53,000 fire staff dealing with 0.5-1 million calls so it made sense to use this capacity.

The Board noted the opportunities for more integrated working with the KFRS, sharing information and reaching the vulnerable people sometimes not otherwise known to health agencies as being in need. In terms of looking at blockages to this it was felt that part of this was a result of the Fire Service being pigeonholed as a reactive service dealing only with fires and also the lack of mature linkages with other agencies. This was contrasted with the experience in terms of community safety where the Fire Service was fully embedded in the Community Safety Partnership and the linkages were well established. It was felt that health agencies could draw upon the experiences of the local authorities and community safety partners in working with KFRS.

The Board was keen to develop closer working and to tap into KFRS services and information, and to promote two way communication. This could help to address issues such as KFRS being unable to follow up patient needs following hospital discharges for example because of lack of information on discharges. The Board was also keen to know the sources from which KFRS received referrals and also to whom it made its own referrals and Mr Rose agreed to provide this data. It was also requested that relevant information be supplied by KFRS to Children's Operation Group (COG) meetings.

It was agreed that CCG and public health officers should meet separately with KFRS to identify opportunities for better integration to exploit the expertise, knowledge and synergies of closer working and to report back to the DGS Health and Wellbeing Board. This could also be linked to the presentation to be given by Emma Hanson, referred to in minute 44. In doing so it was also important to consider how the public access these services and how they know the right people to deal with at each stage of their need from the first point of contact through to its conclusion.

47. HEALTH INEQUALITY GROUPS - AN UPDATE ON PROGRESS ACHIEVED.

The Board received a detailed progress report on the work carried out by the Health Inequalities Groups against identified priorities and how these compared across the areas of Dartford, Gravesham and Swanley.

The Board welcomed the detail of the report but felt that there was a greater need to focus upon outcomes and to highlight the issues of greatest concern or success and how resources were being used. This was considered to be particularly important as many cases involved cross referencing between agencies and there needed to be a clear understanding of the issues. An example of this was the growing gap in life expectancy in different areas which was a major concern but was somewhat lost within the detail of the report. Other opportunities for meaningful benchmarking were discussed and it was suggested that “Mind-the-Gap” might provide a tool for this and that the annual health profiles could also highlight key areas of movement. It was also noted that much of the information in the report was on additional work as opposed to commissioned work, which was already well monitored, and that a lot of data would not be available until the end of the year.

The health prevention agenda was also considered to be key as this was linked to so many health issues, such as obesity and mental health and it was important to understand how successful initiatives such as free gym memberships were in delivering health benefits, but this was not possible from the information in the report. Nor was it possible to assess if services were reaching the right people and people who they would not otherwise reach.

The Chairman stressed that the report was a useful piece of work and interesting in terms of seeing the position in different areas. However for the future he asked if the report could flag up outcome measures and specific key issues for review and decision by the Board.

48. CHILDREN'S OPERATIONAL GROUPS - UPDATE ON PROGRESS ACHIEVED.

The Board received a detailed progress report on the work carried out by the Dartford, Gravesham and Sevenoaks Districts Children’s Operational Groups against identified priorities and outcomes contained in the Kent Health and Wellbeing Strategy relating to children and young people. Progress was compared to national and county performance figures to provide context. The report highlighted areas of good practice, gaps in achievement and where more work could or should be done.

The Board welcomed the report and asked for any significant issues to be highlighted in the progress reports for consideration at future meetings.

49. INFORMATION EXCHANGE

There were no items to be reported.

50. BOARD WORK PLAN.

The Board Work Plan was amended to remove the Urgent Care Review (Feedback) item for the meeting on 11 February 2015 as this was substantially the same item as the Re-commissioning of Walk-in and Urgent Care Services item on the same agenda. An update on Community Services should be added to the agenda for that meeting and Emma Hanson invited to attend and give a presentation.

51. DATES OF BOARD MEETINGS 2015 / 2016

The dates of future Board meetings were noted. Further consideration would be needed over whether to hold a meeting in August and it was suggested that as a start Board members availability should be canvassed.

The meeting closed at 5.19 pm

Councillor R Gough
CHAIRMAN

DARTFORD BOROUGH COUNCIL

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

MINUTES of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on Wednesday 11 February 2015.

Present:

Councillor Roger Gough – Kent County Council (Chairman)
Councillor Ann Allen – Dartford Brough Council
Councillor Jane Cribbons – Gravesham Borough Council
Councillor Tony Searles - Sevenoaks District Council & Swanley Town Council

Sheri Green	Dartford Borough Council
Lesley Bowles	Sevenoaks District Council
Tristan Godfrey	Kent County Council
Terry Hall	Kent County Council
Su Xavier	Clinical Commissioning Group
Debbie Stock	Clinical Commissioning Group
Steve Inett	Healthwatch
Cecilia Yardley	Healthwatch
Emma Hanson	Kent County Council

52. APOLOGIES FOR ABSENCE

Apologies for Absence were received from Graham Harris, Sarah Kilkie, Dr Elizabeth Lunt, Melanie Norris, Anne Tidmarsh and Andrew Scott – Clarke.

53. DECLARATIONS OF INTEREST

There were no declarations of interest.

54. MINUTES OF THE MEETING OF THE DARTFORD, GRAVESHAM, AND SWANLEY HEALTH AND WELLBEING BOARD

The Minutes of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on 17 December 2014 were approved as a correct record of the meeting subject to the correction of the title of Su Xavier in the list of those present.

The following issues arose from the minutes:

Minute 45 – Actions Outstanding From Previous Meetings
It had been reported that a report on the inclusion of health needs in future CIL and S106 agreements was to be considered by the Kent HWB at its January meeting. Unfortunately this report had not yet been presented and it was asked when it would appear.

The Chairman confirmed the intention was still to present the report to the Kent HWB but it was unlikely to be considered before the May meeting.

Board members stressed the concerns felt at local level that clarification was needed on the mechanics of the CIL process and on the benefits that it would bring at regional and local level.

Additionally issues relating to the future demands on the health sector from the many developments in the CCG area were discussed. It was noted that a forward planning group under the Chairmanship of Mike Gilbert, DGS CCG had already been established to consider these matters in relation to the Ebbsfleet development and it was suggested that the TOR for this group be expanded to cover all large developments in the area. It was requested that a presentation be made to a future meeting on the work of the group and the impact of development on the Board area.

Minute 46 – Kent Fire and Rescue Service Presentation
It was reported that a meeting was being arranged to consider closer working with KFRS utilising skills form a number of areas. This would explore a number of issues especially focussing on falls prevention, and a report would be presented to a future meeting.

55. KENT HEALTH AND WELLBEING BOARD AND MATTERS ARISING

The Chairman introduced discussion on the meeting of the Kent HWB held on 17 December 2014. He informed Board Members that he had not been in attendance at the meeting, but had received updates from a number of sources. He also invited others present to provide information on any area of relevance to them.

Item 5 – Strategic Workforce Issues
It was noted that a presentation on Workforce Issues by Philippa Spicer had been well received and would come to our Board in due course.

Some concern was expressed at the issue of training approaches – in particular relating to placements. It was noted that this matter needed investigation to ascertain what was originally agreed and should the need arise it should be revisited. It was noted that the forward planning group discussed at 54 above would also consider workforce issues.

Finally Councillor Cribbon enquired about training for young people to join the Health Services. It was reported that this was something that was being considered for the future, and it was suggested that the use of Studio Schools could be investigated for this purpose.

Item 9 – Better Care Fund- S75 Agreement
It was noted that concern existed amongst local Health and Wellbeing boards regarding the distribution of Better Care Fund grant monies at the local level, specifically regarding Disabled Facilities Grants.

It was reported that there was a statutory requirement for the Kent Board to pass the funding on and that the Chairman would clarify arrangements for this distribution.

Item 10 – Children's Issues
It was reported that a workshop on Children's Issues was to be arranged in the near future and that this would encompass a wide range of child related matters, especially emotional health, disability and LAC (looked after children).

Healthwatch Feedback
Steve Inett reported that Healthwatch were preparing to undertake a consultation exercise amongst stakeholders to identify issues of concern.

Board Members expressed some concern that the approach described may be too broad and believed that the exercise should be more tightly focussed.

Mr Inett therefore agreed that he would contact all Board members by eMail to gain an insight into this matter and would report back to the next Board meeting.

56. URGENT ITEMS

The Chairman reported that there were no urgent items for the Board to consider.

57. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS

The Board received and noted a position statement on actions arising previous Board meetings.

Arising from the report the Board received details relating to the terms of reference and structure of the newly constituted Integrated Operational Commissioning Group (IOCG). The board expressed concerns relating to

- The linkages between the new group and the Health and Wellbeing Board.

- The role of Housing representatives and the progress made in addressing the Think Housing First (THF) initiative.

It was agreed that Debbie Stock, Sheri Green, Sarah Kilkie and Lesley Bowles, together with an appropriate representative of KCC, meet to undertake a review of the IOCG and consider how it might make better use of district expertise, especially on housing, to advance integration.

58. CARE ACT 2014 : IMPLICATIONS

The Board received a synopsis of a presentation from Emma Hanson on work being undertaken to build capacity in the provision of care by:

- the use of existing voluntary groups to provide care and facilitate entry into the care framework where local care provision is not available
- the adoption of a holistic approach to commissioning of services and training voluntary groups as information providers and system navigators,
- the use of the Kent Wardens to recruit local volunteers to act as watchers for groups of vulnerable people
- the administration of care at home services for those with personalised benefits.

The Board noted the report and asked that a full version be circulated to all Board Members for information.

59. RE COMMISSIONING OF WALK IN AND URGENT CARE SERVICES - CONSULTATION OUTCOMES AND PROPOSED ACTIONS

Debbie Stock reported on work which currently was underway to develop a model framework for the commissioning of urgent care services across north Kent.

She informed the Board that the current contracts to deliver these services were due to expire in March 2016, and that it was hoped to deliver new contracts by September of that year.

She also stressed that the model framework was designed to deliver a simple to access 24/7 service, and which it was hoped would outperform the service currently operating in Kent.

Councillor Cribbon suggested that the following points were taken on board in the modelling exercise

- The efficacy of current walk in centres
- The underuse of Gravesham Hospital
- The need to improve the speed of laboratory testing services

The Board noted the report.

60. REPORT FROM MENTAL HEALTH GROUP

The Board received a progress report on the work of the Mental Health Group which detailed a number of the key developments which had taken place relating to

- Eating Disorder: Service Review
- Neurodevelopmental Pathway Review
- Single Point of Access for Secondary Mental Health Services
- Commissioning Intentions for 2014, 2015 and 2016.

Arising from this, Steve Inett of Healthwatch enquired if proposals for "single point of access" to services was to apply across Kent or be limited to a certain area. Additionally he asked if it were proposed to extend mental health liaison officer availability to a full 24/7 service.

Debbie Stock responded that the single point of access proposals were to be limited to the north Kent area initially but it was hoped that these could be rolled out across the whole County, and with regard to the Liaison Officer while this was not a 24/7 service, the availability of this service has been increased to cover later into the night time.

61. BETTER CARE FUND : POLICY DOCUMENT

The Board received and noted a Policy document issued by the Better Care Fund Task Force which set out the framework for the implementation of the Fund. The Chairman noted that Kent had received very good feedback from assessments of the county's BCF submission.

62. INFORMATION EXCHANGE

Members were informed that the Health and Wellbeing Assurance Framework report for February had been published this afternoon, and that copies were to be circulated to Members in the near future.

63. BOARD WORK PLAN

The Board received and noted a report on its work plan for the future and a number of amendments which were to be made.

64. DATES OF FUTURE MEETINGS

The Board considered a proposed programme of meetings for the forthcoming Municipal Year together with details of Member availability for a possible meeting in August 2015.

It was noted that if a meeting was not held in August there would be a substantial gap when the Board did not meet, and that sufficient numbers of

Board members were available to attend such a meeting, providing good representation across partners.

It was therefore agreed

1. That a meeting should be arranged for 19 August 2015; and,

2. To approve the timetable of meetings set out below;

11 February2015
15 April
17 June
19 August
7 October
9 December
24 February 2016
6 April

The meeting closed at 5.20 pm

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Health and Wellbeing Board – Sixth Formal Meeting

Meeting held on Wednesday 28 January 2015 2014 at 09:30am

Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT

Present	**Cllr Andrew Bowles (AB), *Leader, SBC (Chair)*** **Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC*** **Abdool Kara (AK), *Chief Executive, SBC*** **Cllr John Wright (JW), *Cabinet Member for Housing and Lead Member for Health, SBC*** **Patricia Davies (PD), *Accountable Officer, Swale CCG*** **Dr Fiona Armstrong (FA), *Chair, Swale CCG*** **Colin Thompson (CT), *Public Health, KCC*** **Terry Hall (TH), *Public Health, KCC*** **Bill Ronan (BR), *Community Engagement Manager, KCC***	**PSE Jane Hurn (JH), *Mental Health Project Worker, Kent Police*** **Sarah Williams (SW), *Assistant Director, Swale CVS*** **Helen Stewart (HS), *Kent Healthwatch*** **Tristan Godfrey (TG), *Policy Manager, KCC*** **Cllr Chris Smith (CS), *Deputy Cabinet Member Adult Social Care & Public Health, KCC*** **Steve Furber (SF), Vice-Chair, *Swale Mental Health Action Group*** **Jo Purvis (JP), *Strategic Housing and Health Manager, SBC*** **Becky Walker (BW), *Housing Strategy and Enabling Officer, SBC***
Apologies	**Debbie Stock, *Chief Operating Officer, Swale CCG*** **Su Xavier, *Swale CCG*** **Chris White, *Swale CVS*** **Paula Parker, *Commissioning Manager, KCC*** **Mark Lemon, *Strategic Business Advisor, KCC***	**Penny Southern, *Director Learning Disability and Mental Health, KCC*** **Amber Christou, *Head of Housing and Health, SBC*** **Alan Heyes, *Community Engagement Lead, Mental Health Matters***

NO	ITEM	ACTION
1.	**Introductions**	
1.1	AB welcomed attendees to the meeting.	
1.2	All attendees introduced themselves and apologies were noted.	
2.	**Minutes from Last Meeting**	
2.1	The minutes from the previous meeting were approved.	
2.2	Matters arising: ▪ p.1, 2.2: PP to share a list of respite/support services for dementia carers ▪ p.2, 2.2: TH to confirm if there is still a pharmacy at Teynham Street	 **PP** **TH**

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3.	**The Care Act 2014**	
3.1	TG introduced a presentation on the new Care Act. The key points were: ▪ this is the biggest change to social care since 1948; ▪ from April 2015, KCC will have a duty to assess and meet the needs of both service users and carers if they meet the eligibility criteria. The national eligibility criteria will be slightly higher than KCC's existing criteria, which is set at medium; ▪ KCC will also take responsibility for the care needs of eligible prisoners; ▪ the focus will be on outcomes for people and a better quality of life. More support will be offered to carers to them in their role; ▪ KCC are looking at aligning the Kent Health and Wellbeing Strategy and the JSNA with the Care Act requirements so that the outcomes can be measured; ▪ from April 2016, there will be a cap on care costs of £72K; ▪ there could be a large increase in the number of assessments required, which may have capacity and resource implications for KCC; and ▪ AB suggested circulating the paper prepared by KCC for the November Kent Health and Wellbeing Board with the minutes.	**JP**
3.2	Points made in the discussion included: ▪ KCC can delegate most functions except for adult safeguarding responsibilities. It is an option to delegate, not a requirement. KCC are currently looking at potential delegations; ▪ the infrastructure and workforce are in place to do the assessments but there could be an initial large spike in demand for assessments from self-funders and carers. This is an unknown quantity and difficult to plan for; and ▪ potential forecasts have estimated that the number of assessments could increase from 400 per year to 4,000. If this occurred, KCC would have to look at the options of outsourcing some assessments.	
4.	**Mental Health Concordat**	
4.1	JH presented on the Mental Health Concordat. The key points were: ▪ the Concordat is a partnership agreement aimed at helping people experiencing a mental health crisis to get the right support. It is important that they can have access to services 24 hours a day; ▪ where the police come into contact with someone in crisis they are not always the best people to be able to help that person as they don't have access to things like medical records. Kent Police need to ensure they work with other local agencies to get that person the right support and/or assessment; ▪ a key aspect of the Concordat is treating people with dignity and respect	

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4.2	and looking at it as a medical issue rather than a police one i.e. using unmarked police cars or ambulances to transport people rather than marked police cars. This helps to reduce stigmatization of mental health; ▪ Kent Police are currently working with Kent Publish Health around suicide prevention and doing a lot to promote the Live it Well website; ▪ There is a Concordat sub-group looking issues around ensuring people get timely assessments. The three-hour timescale is difficult to deliver on the ground, particularly where there is dual diagnosis with substance or alcohol misuse; and ▪ Kent Police will be having someone from Mental Health Matters in the Control Room so that they can identify at the call stage if a s.136 assessment might be needed. Points made in the discussion included: ▪ there seems to be an increasing demand for VCS services but diminishing resources. Kent Police need to consider funding the VCS to help deliver the Concordat[▪ the CCGs are signed up to the Concordat and are working together on this so that all Kent residents can receive the same service irrespective of where they live. The CCGs also fund the Street Triage service so people can be triaged properly and only receive s.136 assessments where necessary; ▪ there is a need to ensure that all frontline staff are properly trained in dealing with people in mental health crisis, including reception staff, call centre and control centre staff; and ▪ a request was made for Kent Police to come back to the Board in six months to review how this has been working locally in Swale. JP to add to Forward Plan.	**JP**
5.	**Family Nurse Partnership**	
5.1	KCHT were unfortunately unable to attend to present on this item. It was agreed to reschedule for a future meeting.	**BW**
6.	**JSNA Evaluation**	
6.1 6.2	CT gave an overview of KCC's JSNA Evaluation. The key points were: ▪ KCC are looking at how well the JSNA is used by other organisations and how meaningful it is to them; and ▪ KCC would like local HWBs to respond and also member organisations to respond directly. Points made in the discussion included: ▪ it would be more meaningful to have a workshop or focus group on this rather than fill out a questionnaire, so that there can be some more discussion about it; and ▪ AB wrote to Roger Gough previously asking for some form of joint learning event for local HWB Chairs, and this could be included as part of	

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	a wider engagement process.	
7.	**Health Improvement Partnership Update**	
7.1	CT provided an update on the Health Improvement Partnership (HIP). The key points were: ▪ the HIP is a sub-group of the HWB, focussing on public health issues. The first meeting was held on 22 January, and future meetings will be bi-monthly; ▪ the HIP discussed the Local Health Action Plan for Swale and identified a number of priority objectives for the Board to focus on over the next 12 months, taken from the list of priorities agreed at the HWB on 19 November; ▪ the Board asked if these could be circulated and they can then review and feedback. CT to circulate list; ▪ KP asked if he could be provided with a list of attendees of the HIP and any minutes from meetings. CT to provide; and ▪ JP offered to circulate the agreed ToR to remind the Board of the HIP's purpose etc.	**CT** **CT** **JP**
8.	**Better Care Fund**	
8.1	TG updated on the Better Care Fund. The key points were: ▪ the BCF Plan for Kent has now been approved by DoH; ▪ work is underway around the financial arrangements. There will be one pooled budget but with seven distinct chapters for each CCG area. There will be no cross-subsidy from one area to another in the event of poor performance; ▪ Disabled Facilities Grant funds monies will go into the pooled budget and then back out to Districts for 2015/16; and ▪ KCC is looking at the role of local Health and Wellbeing Boards in monitoring and overseeing performance of the BCF at the local level.	
9.	**Kent Health and Wellbeing Board**	
9.1	The papers for the Kent Health and Wellbeing Board were discussed. Points made in the discussion included: ▪ TH raised that there had been a paper due to the go to the Kent HWB about CIL and s.106 agreements but this seems to have been delayed. AK was concerned about a paper on this going to the Kent HWB without any consultation with the Districts as the Local Planning Authorities. KP to ask at the Kent HWB meeting when this paper is due; ▪ it was noted that COGs were mentioned in the Early Years' Service paper but it was still not clear around their role and the link with other groups such as the Children's HWB. There was concern that without a COG there is nowhere to discuss local safeguarding issues with KCC; ▪ one view was that now that there are well-established systems in place	**KP**

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	for joint working was there a continuing role for the Pioneer Group?	
10.	**Partners' Update/AOB**	
10.1	**Swale CCG** ▪ The CCG are undertaking their contracting round with providers for 2015/16. There will be a warm-up event on 11 February for interested suppliers of community services. There will be no significant changes to the community services to be provided. The contract will be for seven years. ▪ Medway Foundation Trust will be presenting to Kent HOSC with Swale CCG. MFT are failing to meet A&E targets of seeing patients within four hours.	
10.2	**Swale Borough Council** ▪ SBC are going through the budget process. There are no proposed cuts to frontline staff, or any Council Tax increase.	
10.3	**KCC** ▪ Children's Social Services will be going through the efficiency process with KCC's efficiency partner as part of the transformation programme.	
10.4	**Mental Health Matters** ▪ A written update on the Wellbeing Cafes will be circulated. SF to provide to BW.	**SF/BW**
10.5	**Kent Healthwatch** ▪ Healthwatch will be holding a Swale public engagement event on 11 March. SW offered to publicise through the CVS networks	**SW**

Next meeting date: **Wednesday 18 March 2015***

Time: **9.30am – 11.30am**

Location: **Committee Room, Swale Borough Council**

***This meeting will be in public**

Future Meetings Dates (all 9.30 – 11.30 at Swale House):

20 May 2015

15 July 2015

16 September 2015

18 November 2015

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WEST KENT CCG HEALTH AND WELLBEING BOARD

DRAFT MINUTES OF THE MEETING HELD ON TUESDAY 20TH JANUARY 2015

Present:

Dr Bob Bowes (Chairman)	Chair, WK CCG
Gail Arnold	Chief Operating Officer, WK CCG
William Benson	Chief Executive, Tunbridge Wells District
Cllr Annabelle Blackmore	Leader of Maidstone Borough Council
Hayley Brooks	Health and Communities Manager, Sevenoaks District Council, substituting for Lesley Bowles
Alison Broom	Chief Executive, Maidstone Borough Council
Cllr Alison Cook	Sevenoaks District Councillor
Tristan Godfrey	Policy officer, Kent County Council, substituting for Mark Lemon
Cllr Roger Gough	Chair of Kent Health and Wellbeing Board
Jane Heeley	Tonbridge and Malling Borough Council
Fran Holgate	HealthWatch
Steve Inett	Chief Executive, HealthWatch, Kent
Dr Tony Jones	GP Maidstone
Reg Middleton	Chief Finance Officer, WK CCG
Penny Southern	Director of Learning Disability and Mental Health, Kent County Council
Malti Varshney	Consultant in Public Health, Kent County Council
Cllr Lynne Weatherly	Tunbridge Wells Borough Councillor

In attendance:

Francesca Guy	Deputy Company Secretary, WK CCG

1. WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting. Apologies had been received from the following:

Julie Beilby
Lesley Bowles (Hayley Brooks attended on her behalf)
Dr Caroline Jessell, NHS England
Cllr Mark Rhodes
Dr Andrew Roxburgh
Mark Lemon (Tristan Godfrey attended on his behalf)
Dr Sanjay Singh

2. MINUTES OF THE MEETING HELD ON TUESDAY 18TH NOVEMER 2014.

RESOLVED: That the minutes of the meeting held on Tuesday 18th November 2014 be approved as a correct record.

3. MATTERS ARISING

There were no matters arising.

4. UPDATE ON SECTION 75 – BETTER CARE FUND

Reg Middleton outlined the purpose of the Better Care Fund and noted that a legal structure was required to support moving to an operational basis. Mr Middleton gave an update on the progress towards the development of a section 75 agreement between the CCGs in Kent and Kent County Council and the work that needed to be completed before April 2015. Mr Middleton noted that one section 75 had been agreed for the whole of Kent, with sufficient localisation of plans for each of the CCG areas contained in 7 separate annexes. The Kent Health and Wellbeing Board would be required to approve the section 75 at its meeting in March 2015. Mr Middleton noted that this was the first step towards greater integration of services and would therefore look different in years 2 and 3.

Steve Inett asked where the monthly dataset would be reviewed and how it would be evaluated to ensure that the process was working. Mr Middleton responded that it would be generated at a local level and reviewed by the Health and Wellbeing Board. Mr Inett noted that the majority of the data collected was quantitative and he offered to speak with patients in order to inform this data with some qualitative feedback. The Chair responded that the dataset was nationally mandated, but agreed that it would be useful to have this additional local information.

Dr Jones commented that a significant amount of the interface of services happened around care homes and therefore the Health and Wellbeing Board should have a role in discussing residential care home provision.

Mr Middleton commented that benefits had already been seen from the exchange of information between officers of KCC and the CCGs. The next step was to identify opportunities to make further progress.

A discussion followed about whether there would be a role for the voluntary sector moving forward. Mr Middleton responded that the Better Care Fund provided scope to manage the provision of services differently and elements of the fund allowed for investment in the voluntary sector. Gail Arnold added that agreement would be needed on how the voluntary sector would be represented. Dr Jones suggested that the Citizens Advice Bureau in Maidstone and Age UK were two elements of the voluntary sector that should be represented.

Cllr Alison Cook remarked that the voluntary sector was expected to provide professionalism on behalf of the professionals and often the bidding process did not allow sufficient time for staff to be appropriately trained before the next round of bidding commenced. The Chair added that there was a difference between those providers who provided a good service and those providers who were good at bidding for contracts.

The Chair asked Mr Middleton to provide the first performance report at the next meeting of the Health and Wellbeing board in March 2015 as this would provide a baseline for the new financial year. **Action: Reg Middleton**

5. SCOPING OF WEIGHT MANAGEMENT AND OBESITY

Jane Heeley introduced this item and noted the paper articulated the key priorities around "Healthy Weight" and the areas to hold commissioners to account for improving obesity rates in the West Kent area. Ms Heeley noted the proposal was to set up a task and finish group with four key aims:

- To undertake a critical analysis of strategic plans of all partners to identify any gaps in the provision of relevant services and gaps in the integration of those services;
- To develop an understanding of why these gaps exist and make recommendations to address them;
- To propose a process for co-ordinating the wide range of stakeholders involved in this area; and
- To make recommendations for addressing any "quick wins".

Ms Heeley gave an update on how the recommendations from the Childhood Obesity Task and Finish Group had been developed since it presented its final report in April 2014. Ms Heeley noted that the services for children and young people were currently not sufficiently wide to address all age groups and referral rates to some commissioned services were very poor. Health professionals often found it difficult to engage with patients about their weight and training would therefore be a key focus of the task and finish group.

Dr Tony Jones agreed with the point about holding difficult conversations with patients and noted that his practice was looking to use protected learning time to address this issue. Dr Jones also noted that his practice was organising a cyclathon and this was perhaps something that GPs and Members of the Council could promote within the population.

In response to a question from Roger Gough, Ms Heeley commented that the role of planning, housing and other district services would be included within the scope of this work.

Malti Varshney commented that there would need to be some co-ordination of communications and agreement on the branding. It was suggested that a private corporate communications company with a corporate social responsibility remit could be engaged for this project. It was also suggested that the branding could be linked to Change 4 Life. Ms Varshney agreed to discuss this with the Chair and to report back to the meeting. **Action: Bob Bowes and Malti Varshney**

RESOLVED: The Health and Wellbeing Board agreed the following:

- the proposed aims and scope of the Task and Finish Group as outlined in the paper;

- that the operational membership of this group comprised initially the lead consultant in Public Health and Public Health Specialist for Healthy Weight, District lead for Healthy Weight and CCG lead for healthy weight; and
- Cllr Lynne Weatherly was appointed to the Group as designated authority from the Board to progress recommendations.

6. DELIVERY OF INTEGRATED PROVISION DEFINING EXPECTATION AND DELIVERY AS A BOARD

The Chair opened the discussion by stating that the paper contained recommendations for the introduction of a System Leadership Forum for commissioners and providers in West Kent. The purpose of the forum was to provide a vehicle to operationalise commissioning ideas and to provide a sense check between commissioners and providers.

Mr Inett commented that, as these meetings would not be held in public, it would be useful to understand the key issues discussed to avoid any duplication of effort.

Cllr Gough asked what the role of the System Leadership Forum would be in relation to the Better Care Fund. The Chair responded that the role of the Health and Wellbeing Board was to set the overall strategic direction and the role of the System Leadership Forum would be to operationalise the strategy, which would include the Better Care Fund.

Mr Benson commented that a better understanding was needed of the breadth of the services being commissioned both CCG-wide and county-wide.

Dr Jones commented that the role of the Urgent Care Board was very similar, although with a narrower focus. Dr Jones also added that this type of group would benefit from the insight that comes from people on the ground.

The following comments were made on the paper:

- NHS England had a role in checking that plans were aligned and it was not clear whether the System Leadership Forum would also have a role in this.

- The figure on page 7 of the paper should include the Kent Health and Wellbeing Board as well as the West Kent Health and Wellbeing Board.

- The paper should have a stronger focus on reducing inequality and should be emphasised more strongly in the paper.

- The role of local authorities was not clear.

The Chair agreed to update the paper to reflect the comments made. **Action: Dr Bob Bowes**

7. PROGRESS ON CHILDREN'S OPERATIONAL GROUP FOR WEST KENT

Tristan Godfrey gave an explanation of the background of Children's Operational Groups and the options for relationships with other bodies.

Cllr Roger Gough commented that the multi-district model operating in Dartford, Gravesham and Swanley seemed to function well, with co-ordinated reporting to the CCG-based Health and Wellbeing Board.

William Benson commented that it was not clear whether a Children's Operational Group existed in Tunbridge Wells. Hayley Brooks from Sevenoaks agreed to work with all districts to understand what gaps there were in the arrangements and work with Mr. Benson to develop an overview of the relationship between the different bodies and make recommendations for the Children's Operational Group, Children's Health Wellbeing Board and Local Health and Wellbeing Board. Ms Brooks and Mr Benson agreed to report back to the March West Kent Health and Wellbeing Board. **Action: Hayley Brooks/William Benson**

A discussion followed about the age range that the COGs covered and it was agreed that it should be up to 25 years old. The Health and Wellbeing Board agreed that this should be consistent across the districts in West Kent.

8. LEADS FOR TASK AND FINISH GROUPS

Malti Varshney commented that she thought that it would be useful to have Member leads alongside the officer leads for Task and Finish Groups. The Health and Wellbeing Board agreed the principle and agreed that Cllr Lynne Weatherly would be the member lead for the Obesity and Healthy Weight Task and Finish Group.

9. ANY OTHER BUSINESS AND DATE OF NEXT MEETING

Incentive Schemes

The Chair asked whether it would be useful to share with the Health and Wellbeing Board the incentive schemes that CCGs were offering to providers in order to try and steer behaviour. In the discussion that followed, it was agreed that it would be useful for the 2015/16 CQUINs to be reported to the May meeting of the West Kent HWB, which would allow the board to understand the current position with a view to influencing the 2016/17 CQUINs. **Action: Gail Arnold/Reg Middleton**

The date of the next meeting is on Tuesday 17th March 2015 at Sevenoaks District Council Offices, Argyle Road, Sevenoaks Kent TN13 1HG.

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