Ashford Clinical Commissioning Group

# Operational Plan

# April 2014- March 2016

**v0.2**

| Integrated Urgent Care Centre | **Urgent Care** |
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## Description

Evidence Base

- East Kent Integrated Care Pilot 2009
- ECIST review of the Urgent Care System 2010
- Clinical Systems Model for Integrated Urgent Care and Long Term Conditions 2012
- Kings Fund review of Urgent and Emergency Care NHS South of England 2013.

Key Changes

- enhanced GP out of hours service to replicate what is provided in hours;
- enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services;
- consistently responsive and reliable service 24/7;
- integration of the out of hours service with other care providers;
- clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and
- proactive case management.

High Level Benefit Assessment

- Provide a rapid multi-disciplinary assessment of patients quickly
- Provide rapid access to a range of services that will ensure that patients are managed seamlessly and are better supported to cope within their local community.

Key Risks

- Quality / complaints
- Human resources / organisational development / staffing / competence
- Adverse publicity / reputation

## NHS Outcomes Framework

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Alastair Martin |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Kent Community Health NHS Trust<br>Kent County Council<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | | | |
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| **Key Milestones** | | | |
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| Transformation of Outpatient Services | **Planned Care** |
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**Description**

Key Changes

- Pre-Referral Advice and Guidance Service
- One-Stop Clinics
- Improved Triage

High Level Benefit Assessment

For patients

- Appropriate referral to the right clinician
- Management of their condition by local clinicians
- Reduced attendances in acute settings

For GPs

- Education resource
- Reduces redirection/rejected referrals
- Reduction in overall referrals

For provider

- Only those patients that need to be in clinic are seen
- More diagnostic tests, where appropriate, can be completed prior to referral
- Improves RTT timelines where redirection of referrals has added delays in the past

For CCG's

- Confidence that referrals to secondary care are appropriate
- Potential for savings where patients are not referred and managed in primary/community care

Key Risks

- Potential for provider to miscode response and therefore output data maybe of questionable quality
- Percentage of referrals avoided provides minimal savings
- Engagement with GPs

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Leads** | Paula Smith<br>Sue Luff<br>Felix Robinson |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | | | |
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| **Key Milestones** | | | |
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| Macula Oedema | **Planned Care** |
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## Description

Evidence Base

- NICE Technology Appraisal Guidance
- Diabetic Macular Oedema (DMO; TA274)
- Wet Age-Related Macular Degeneration (WAMD; TA155)

Key Changes

- A hub and spoke type service model to provide patients with community monitoring facilities and a central acute site(s) for the treatment/drug administration

High Level Benefit Assessment

- Patients would not need to attend acute hospital sites for every appointment.
- Patients seen in a timely fashion and impact on their vision is minimised
- Improved delivery of high quality and value for money monitoring service that will also provide the maintenance a patient requires between injections
- Improved access and choice
- Delivers greater consistency of treatments
- Equity of services across the localities which enhances patient experience and reduces wait times

Key Risks

- Fragmentation of service
- Patients confused where their next treatment will be provided
- Community provider monitoring patients fails to identify developing problems
- Agreed tariff too low to be viable & attract providers

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Paula Smith |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Local Optometrist Committee<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | | | |
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| **Key Milestones** | | | |
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| Dermatology | **Planned Care** |
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**Description**

Key Changes

- Prime contractor will be responsible for developing and implementing an integrated and coordinated programme of Dermatology care
- Services will be commissioned on the basis of "outcome" rather than separate services for each condition.

High Level Benefit Assessment

- Reducing fragmentation in the patient pathway.
- Reducing confusion for GPs with regard to where to refer.
- The patient being seen by the right clinician in the right place first time.
- Ensuring the right investigations is undertaken.
- Creating efficiencies and financial savings.
- Better clinical effectiveness and increase quality of service.
- Monitoring based on outcomes.
- Supports education in primary care.

Key Risks

- Conflicts of interest from current providers engaged within the Task and Finish Group
- Destabilisation of the Trusts Cancer services
- Inability to procure a new service by October.

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Laura Counter |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Kent Community Health NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | | | |
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| **Key Milestones** | February 2014 | Service Review | |
| | March 2014 | Redesign | |
| | October 2014 | Implement changes | |
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| Transformation of ADHD Service | **Mental Health** |
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**Description**

Evidence Base

- NICE Guideline CG72 Attention Deficit Hyperactivity Disorder (ADHD) 2008

Key Changes

- Integrated all-age pathway, reducing need to transition across paediatric and adult services
- Increased community based service provision
- Shared care between GPs and specialist services

High Level Benefit Assessment

- Improve the recognition, accurate diagnosis and treatment of ADHD in children, young people and adults
- Limit the impact of late initiation of treatment
- Improve the quality of care and may reduce the number of mental health contacts, with the associated costs

Key Risks

- Lack of engagement and buy in to the transformation of services from stakeholders particularly at the early stages of the children's pathway
- GPs unwilling to sign up to an ADHD shared care and prescribing protocol

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Jacqui Davis |
| **Key Partners** | Kent and Medway Partnership Trust<br>Sussex Partnership NHS Trust<br>East Kent Hospitals University NHS Foundation Trust<br>Medway NHS Foundation Trust<br>Kent Community Health NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | | | |
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| **Key Milestones** | March 2014 | Determine the level of service required | |
| | June 2014 | Service design (including prescribing arrangements) | |
| | September 2014 | Development of shared care and prescribing protocol | |
| | March 2015 | Procurement process and implementation of new service | |
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| Eating Disorders Service | **Mental Health** |
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**Description**

Strategic Fit

- Kent Health and Wellbeing Strategy

Evidence Base

- NICE guidelines for Borderline Personality Disorder

Key Changes

- TBA

High Level Benefit Assessment

- To improve the condition of patients with eating difficulties or disorders, whereby they are able to maintain their physical and psychological health either with no or less specialist assistance
- To improve the nutritional health of patients with eating difficulties or disorders
- A reduction in subjective distress of patients
- To liaise with secondary and tertiary care providers to provide appropriate and timely care for patients identified as needing more intensive treatment or admission

Key Risks

- Derogation of funds from NHSE to CCGs – no agreement in place between CCGs regarding fair share of funding and resources

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Jacqui Davies |
| **Key Partners** | Kent and Medway Partnership Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | | | |
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| **Key Milestones** | | | |
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| Autistic Spectrum Conditions Diagnostic Assessment Service | **Learning Disabilities** |
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**Description**

Strategic Fit

- It was identified in 2010 that there was no clear diagnostic or care pathway for adults with high functioning autism and Aspergers syndrome in Kent
- The current capacity of the service is 60 diagnostic assessments a year, and the waiting list as of July was 280 patients

Evidence Base

- NICE quality standards

Key Changes

- Increase capacity for assessment service

High Level Benefit Assessment

- The backlog of people waiting for diagnostic assessment will be addressed
- There will be improved multi disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- Formal diagnosis ensures individuals are not referred to inappropriate health, social care and community and voluntary services.
- Carers and families will have a greater understanding of autism as a result of the development of this service.
- The service would meet key requirements of national policy and guidance.

Key Risks

- Risk that current level of referrals may not be a true representation of future demand for service – the prevalence data suggests referrals could continue to increase
- Risk that current provider cannot sustain current service which may pre-empt closure of the current service.

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Sue Gratton |
| **Key Partners** | Kent County Council<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Service meeting NICE guidelines | | |
| | Reduced waits for diagnosis | | |
| | Increased referrals | | |
| **Key Milestones** | October 2014 | Additional staff recruited | |
| | January 2015 | New capacity available | |
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| Winterbourne Joint Plan | **Learning Disabilities** |
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**Description**

Evidence Base

- The *Winterbourne Concordat: Programme of Action* (DH 2012)

Key Changes

- Agree a personal plan for each individual that is inappropriately placed in CCG or NHS England commissioned learning disability or autism in-patient services and put the plans into action so that all individuals receive personalised care and support in the community no later than 1 June 2014
- Put in place a locally agreed joint plan for high quality care and support services by April 2014, which accords with the model of good care to ensure that a new generation of inpatients do not take the place of people currently in hospital.

High Level Benefit Assessment

- People with learning disability and autism who have complex mental health or behaviour problems will experience more integrated care and support in the community
- There will be improved multi-disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- There will be reduced reliance on the use of high cost in-patient services
- Clinical consultancy and support would be available for other professionals in mainstream services to enable them to make reasonable adjustments.
- The service would meet key requirements of national policy and guidance.

Key Risks

- Lack of funding from NHSE Specialised Commissioning renders commissioning recommendations unaffordable for CCGs and Local Authority
- June 2014 deadline for discharges of current in-patients not met due to requirement to undertake procurement process for new services

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | Bethan Haskins | **Managerial Lead** | Sue Gratton |
| **Key Partners** | Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduced number of hospital admissions | | |
| | Reduced length of stay for hospital admissions | | |
| **Key Milestones** | Completed | Identify current in-patients for discharge | |
| | February 2014 | Details of each patients support and accommodation needs | |
| | March 2014 | Consult on new care pathway and models of care | |
| | April 2014 | Final Joint Plan | |
| | June 2014 | All current in-patients discharged or agreed discharge plan / procurement being implemented. | |
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| Multi-agency whole system approach for supporting disabled children and young people with challenging behaviour | **Child Health and Maternity** |
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## Description

Strategic Fit

- Kent Health and Wellbeing Strategy

Evidence Base

- Department of Health's Report into Winterbourne View
- Children and Families Bill
- Kent Sufficiency Strategy (2013)

Key Changes

- A new multi-agency integrated pathway involving professionals working at universal, targeted, specialist and highly specialist levels Integrated assessments and care planning process aligned to the new Education Health and Care plans

High Level Benefit Assessment

- Children and young people are able to remain living at home with their families.
- Children and young people are educated in a Kent school.
- Children and young people are able to maintain or develop friendships and access local community services.
- Families feel confident in managing their son or daughter's challenging behaviour and are able to participate in everyday activities.

Key Risks

- Delay in recruiting the right staff with the right level of training and experience.
- Unable to agree contract variation to support the implementation of the transformation programme.
- Decision by any partner not to invest in this transformation programme.

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|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Martin Cunnington |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Kent County Council<br>Sussex Partnership NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduce the number of out of county placements for children with severe autism and challenging behaviour. | | |
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| **Key Milestones** | June 2014 | Baseline data and scope of the evaluation agreed. | |
| | September 2014 | New outcome measures and KPIs included in a range of contracts and a central data collection system agreed. | |
| | December 2014 | Remodelling and training within CAMHS, social care and education to implement new integrated pathway across universal, targeted and specialist services | |
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| Early Pregnancy Assessment Unit | **Child Health and Maternity** |
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**Description**

Strategic Fit

- Kent Health and Wellbeing Strategy
- Kent's Children and Young People's plan 'Every Day Matters'
- Kent Health Inequalities Action Plan "Mind the Gap"

Evidence Base

- NICE Guidelines for Ectopic pregnancy and miscarriage

Key Changes

- Ensure pathways are transparent, equitable and clearly communicated
- Single Point of Access (SPA) led by a clinician who will feed into primary care and OOH services that link to the A&E pathways.
- Improved access to scanning appointments, or explore having a scanner available in primary care

High Level Benefit Assessment

- Ensure the right care is given at the right time, at the right place and by the right professional
- Deliver the best, proactive care to prevent avoidable complications and interventions. Supporting the reduction of adverse outcomes of pregnancy
- Enable and empower women and GPs to use appropriate access routes to the services
- Improve transparency and accuracy of coding to result in more efficient use of resources
- Continued reduction of A&E attendances – improve pathways and reduce activity though this route

Key Risks

- Destabilisation of services
- Lack of engagement
- Projected benefits are not fully realised.

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| **Clinical Lead** | | **Managerial Lead** | Adam Warmington |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduced attendance at A&E for pregnancy complications | | |
| | Waiting times following GP referral | | |
| | Proportion of scans undertaken on same day | | |
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| **Key Milestones** | June 2014 | Research and understand best practice | |
| | July 2014 | Implement new EPAU pathway | |
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| Transformational of Urgent Care for Children and Young People | **Child Health and Maternity** |
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**Description**

Evidence Base

- DH and DfE, Improving Children and Young People's Health Outcomes – a system wide response (2013)
- DH, Report of Children and Young People's Health Outcomes Forum (2012)
- RCGP in partnership with RCPCH and RCN, Commissioning a good child health service (2013)
- Standards for children and young people in emergency care settings (2012)
- NHS Institute for Innovation and Improvement, Focus on: Children and Young People Emergency and Urgent Care (2010)

Key Changes

- New urgent and emergency care clinical network for children and young people
- Use of assistive technology
- Working with Public Health and the School Nursing Service to deliver key messages in schools.
- Develop lesson plans for use in schools around PSHE.

High Level Benefit Assessment

- Parents have an increased level of awareness and confidence in being able to support their children with common illnesses which may require urgent or emergency care.
- Children and young people, where it is clinically safe are treated and supported outside of hospital in their local community.
- Increase in confidence to manage their condition.

Key Risks

- Destabilisation of services
- Lack of engagement
- Services not streamlined
- Efficiencies and quality not meeting expectations

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| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Kent Community Health NHS Trust<br>Kent County Council<br>Sussex Partnership NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduction in A&E attendances | | |
| | Reduce short stay admissions | | |
| | Increased community based support | | |
| **Key Milestones** | December 2014 | Reviews of existing services complete | |
| | June 2015 | New system design complete | |
| | | | |

| Admiral Nursing | **Long Term Conditions** |
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**Description**

Strategic Fit

- Dementia has been identified as a priority for the Kent HWB as well as the CCG.
- The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy 2009 and the Prime Ministers Dementia Challenge 2012.

Evidence Base

- NICE QS30 Supporting people to live well with Dementia. Quality Standard 30 (NICE 2012)
- NICE CG42 Dementia Support people with dementia and their carers in health & social care (NICE 2005)

Key Changes

- The existing Admiral Nurse be integrated into the Neighbourhood Care Teams
- The service will need to develop stronger working links with Age UK (who currently hold the contract for Dementia Café in Canterbury).
- A combination of clinic and home visit approach is explored and adopted to create capacity, utilising existing voluntary sector accommodation where appropriate (Age UK etc.)
- Improve links with carers rapid response and other jointly commissioned services i.e. Crossroads crisis service.

High Level Benefit Assessment

- Reduced carer admissions
- Improved access for carers/families to support them in caring role.
- Integrated working between Neighbourhood Care Teams/admiral nursing/voluntary sector
- Capacity for service to educate other professionals.

Key Risks

- Capacity of the team across other parts of East Kent means that the administrative post is diluted

## NHS Outcomes Framework

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| Securing additional years of life for people with treatable mental and physical health conditions. | Improving the health related quality 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 with mental and physical health conditions 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. |

| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Lisa Barclay |
| **Key Partners** | Kent Community Health NHS Trust<br>Kent County Council<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduced admissions due to carer breakdown | | |
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| **Key Milestones** | | | |
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| Cardiology | **Long Term Conditions** |
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**Description**

Key Changes

- Review all of the existing services
- Develop an integrated service model
- Services commissioned on the basis of "outcome" rather than separate services for each condition
- Care delivered in a community setting
- Clear and responsive referral routes into secondary care services.

High Level Benefit Assessment

- Reducing fragmentation in the patient pathway.
- Ensuring the patients are seen by the right clinician in the right place first time.
- Creating efficiencies and financial savings, providing value for money against existing services
- Better clinical effectiveness and increase quality of service.
- To improve health outcomes through earlier diagnosis and treatment of common cardiology conditions
- To reduce the number of referrals, so far as clinically appropriate, to secondary care
- To establish a robust communication mechanism between all parties providing and receiving the service.

Key Risks

- KCHT may not wish to support the continuation of the GPwSI service on an interim basis
- Lack of data on the GPwSI service to review effectiveness
- Clinicians ability to dedicate time to the Task and Finish Groups

## NHS Outcomes Framework

| 1 | 2 | 3 | 4 | 5 |
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| Securing additional years of life for people with treatable mental and physical health conditions. | Improving the health related quality 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 with mental and physical health conditions 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. |

| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Rachel Grout |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Kent Community Health NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduction in GP referrals | | |
| | Reduced admissions | | |
| | Improved life expectancy | | |
| **Key Milestones** | February 2014 | Service review completed | |
| | April 2014 | Full Business Case | |
| | October 2014 | Implementation | |
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| Memory Assessment | **Long Term Conditions** |
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**Description**

Strategic Fit

- The provision of early diagnosis for people with dementia is identified as an objective in the National Dementia Strategy 2009
- Prime Minister's Dementia Challenge, 2012 which sets a target diagnosis rate of 66% by 2015 (against expected prevalence).

Key Changes

- The pathway envisages in future that the majority of people with dementia will be reviewed and monitored in primary care.
- Dementia screening should be undertaken in primary care to exclude other reasons for the cognitive impairment
- Magnetic resonance imaging (MRI) is suggested as the preferred modality to assist with early diagnosis and detect subcortical vascular changes, the suggestion would be that the scan should be ordered in primary care.

High Level Benefit Assessment

- Care closer to home by increasing the assessment and treatment available in primary care.
- A more multi disciplinary approach to patients will also help to support the integration of services
- Free up capacity in the memory assessment service for those people who need more specialist input

Key Risks

- Redesign of pathway does not increase capacity in memory assessment services leading to delays in assessment.
- Future modelling of local tariffs and activity indicate current budget is insufficient.
- Prescribing will continue to be a cost pressure unless appropriate agreements are reached.

## NHS Outcomes Framework

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Linda Caldwell |
| **Key Partners** | Kent and Medway Partnership NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduction in admission to acute hospital beds | | |
| | Time of referral to the service. | | |
| **Key Milestones** | January 2014 | Review additional data, eg scanning data, number of referrals converted to diagnosis. | |
| | February 2014 | Second workshop for dementia leads | |
| | Mid February 2014 | Agree specification for cluster 18 | |
| | April 2014 | Initial evaluation of Cantabmobile pilot | |
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| Dementia Out Of Hours Crisis Support | **Long Term Conditions** |
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**Description**

Strategic Fit

- Dementia has been identified as a priority for the Kent HWB as well as the CCG. The business supports the desire to deliver care as close to home as possible.
- The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy,2009 and the Prime Ministers Dementia Challenge, 2012.

Key Changes

- The proposal is to develop existing community services
- This enhanced service would provide an out of hours response for both older people with functional problems as well as people with dementia
- The service would be available to both patients known to the secondary mental health services and new referrals and would deliver a service to individuals in their own homes, including care homes
- The service will be targeted at those patients requiring an urgent response from mental health services and those patients who needs may require a joint response between community nursing and mental health services because a physical problem has enhanced their level of confusion.

High Level Benefit Assessment

- Enable older people to remain in their own home (which could be a care home) at times of crisis.
- Avoid unnecessary hospital attendances and admissions.
- Facilitate hospital discharge

Key Risks

- Inability recruit to additional posts will impact on service delivery
- Service does not ultimately deliver savings.

## NHS Outcomes Framework

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Linda Caldwell |
| **Key Partners** | Kent and Medway Partnership Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduction in admission to acute hospital beds | | |
| | Time of referral to the service. | | |
| **Key Milestones** | January 2014 | Undertake modelling to identify hours service needed. | |
| | February 2014 | Agree activity and KPIs for inclusion in KMPT contract | |
| | Mid February 2014 | Advertise for posts | |
| | May 2014 | Service fully implemented | |
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| Falls Strategy | **Long Term Conditions** |
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**Description**

Strategic Fit

- Kent has an aging population, the over 65 population is expected to rise by at least 15% over the next 5 years (more than 20% for over 85 years).

Evidence Base

- One in three people aged 65+ will fall each year and one in two people aged 80+ will fall each year (NHS Confederation, April 2012)
- Falls account for approx. 10 to 25% of ambulance callout (NHS Confederation).
- NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions

Key Changes

- Screening of adults who are at a higher risk of falls
- Integrated multi-disciplinary assessment for the secondary prevention of
- falls and fractures
- Use of standardised Multifactorial Falls Assessment and Evaluation tool
- across Kent
- Availability of community based postural stability exercise classes
- Follow on community support for on-going maintenance closer to home

High Level Benefit Assessment

- Improve access to services
- Reduce hospital admissions related to falls by preventing the patient from having a second fall
- To reduce the number of health and social care activity related to falls and fracture in older people
- Improve patient experience of services
- Improve outcomes for patients

Key Risks

- Public Health timescales for the training and delivery of Postural Stability Instructors may not align with the delivery of the integrated pathway.

## NHS Outcomes Framework

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Rachel Grout |
| **Key Partners** | Kent Community Health NHS Trust<br>Kent County Council<br>Local CCGs<br>Kent Fire and Rescue Service | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduced falls related admissions | | |
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| **Key Milestones** | March 2014 | Scoping exercise complete | |
| | April 2014 | Full Business Case | |
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| Community Equipment Loan Store | **Long Term Conditions** |
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**Description**

Key Changes

- Procure joint social and health care loan store service
- Implement seven day working
- Faster, more responsive, service appropriate to patient need

High Level Benefit Assessment

- Creating efficiencies and financial savings, providing value for money against existing services
- Reduction in admissions by ensuring patients have access to necessary equipment allowing them to remain living in their own homes

Key Risks

- Significant investment required
- Unable to identify provider through procurement process
- Implementation of new service does not meet objectives
- Unable to gain support across health and social care for new service specification

## NHS Outcomes Framework

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Kent Community Health NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduced admissions | | |
| | Reduction in length of stay and delayed discharges | | |
| **Key Milestones** | October 2014 | Commence tender exercise | |
| | April 2015 | Implement new service | |
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| Expansion of Health and Social Care Team | **Long Term Conditions** |
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**Description**

Evidence Base

- Neighbourhood Care Team was implemented in February 2013, A&E attendance and admission avoidance achieved in line with plans

Key Changes

- Make the current H&SCC roles substantive within NCT, recognising the role functions as a central point of access and service navigation for practices.
- Review measurement of savings and test cost assumptions on patient cohort where admission avoidance achieved.
- Increase the H&SCC roles to cover Sunday between 10-2pm
- Extend current NCT team cover for long term conditions, to allow service cover until 8pm at night (currently 5pm), with an on call service being available for care homes 8-8, Mon-Sun
- Improve working relationships between Discharge Referral Service and community care to reduce LoS
- Encourage use of integrated team through H&SCC, by Out of Hours GP Provider.
- Embed use of Share My Care across EKHUFT/KCHT/IC24 and Secamb to reduce A&E attendances and admissions.

High Level Benefit Assessment

- Continue to reduce A&E attendances in 65+ age group – absorb growth in population attendances
- Improve provider integration

Key Risks

- Unable to recruit additional staff
- Service does not meet expected outcomes

## NHS Outcomes Framework

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | |
| **Key Partners** | Kent Community Health NHS Trust<br>Kent County Council<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduced admissions | | |
| | Reduction in length of stay and delays in discharges | | |
| **Key Milestones** | March 2014 | Trial extended hours | |
| | June 2014 | Review outcome of trial peroid | |
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| Personal Health Budgets | **Long Term Conditions** |
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**Description**

Strategic Fit

- From 1st April 2014 everyone eligible for NHS Continuing Healthcare funding will have a right to ask for a personal health budget

Evidence Base

The final national evaluation of the personal health budget pilot programme was released in May 2013. The key findings of the evaluation were:

- 72.6% of budget holders reported their budget having a positive impact on their independence
- 67.9% reported a positive impact on being supported with dignity and respect
- 67.7% reported a positive impact on being in control of their support
- 63.9% reported a positive impact on their mental wellbeing

Key Changes

- Implement a robust governance system for assessment and planning linked to the SE7 SEN and Disabled Children Pathfinder and the establishment of the new Education, Health and Care Plans.
- Implement a multi-agency joint commissioning approach to the provision and monitoring of a personal budget.

High Level Benefit Assessment

*Benefits to budget holders and carers*

- Greater choice and control
- Improved alignment with patients personal life and circumstances

*Wider system benefits*

- Greater transparency in the allocation of NHS funds
- Greater integration
- Greater innovation and service development

Key Risks

- Section 75 agreement not completed by April 2014
- Inability to recruit broker resources
- Unable to agree clinical quality monitoring and support with existing providers

## NHS Outcomes Framework

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Marie Reynolds |
| **Key Partners** | Kent County Council<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Satisfactory levels of positive patient feedback. | | |
| | All PHB referrals are processed following agreed procedures within agreed timeframes. | | |
| | Tracking and comparison of PHB costs against traditional care package cost baseline provided through Decision Support Tool (for CHC). | | |
| | Reduced acute admissions and re-admissions and reduced A&E attendances, ICT referrals. | | |
| | | | |
| **Key Milestones** | Mar 2014 | Completion of Section 75 agreement | |
| | Jul 2014 | Broker recruitment and training completed | |
| | Aug 2014 | Development and approval of joint assessment processes for children with SEN and Disabilities | |
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| Pulmonary Rehabilitation Service | **Long Term Conditions** |
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**Description**

Strategic Fit

- Respiratory disease is the third most common cause of chronic ill health in the UK, (Thorax Journal)
- 21% of adults recorded as “smokers”

Key Changes

- Increase capacity in the Pulmonary Rehabilitation Service
- Encourage and facilitate patient self-management exercise groups
- Ensure consistency in acute sites operate across East Kent

High Level Benefit Assessment

- Reduced duplication and meet existing gaps in provision – clear patient pathway
- Reduced unnecessary appointments by improving patient self-management
- Equitable service across East Kent
- Closer working relationships between the acute trust and community clinicians
- Accurate Asthma and COPD registers, and achievement of respiratory QoF points

Key Risks

- Workforce development
- No increase in referrals

## NHS Outcomes Framework

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| Project Accountability | | | |
|---|---|---|---|
| **Clinical Lead** | | **Managerial Lead** | Kim Eaglestone |
| **Key Partners** | East Kent Hospitals University NHS Foundation Trust<br>Kent Community Health NHS Trust<br>Local CCGs | | |
| **Delivery in 2014-16** | | | |
| **Key Measures** | Reduction of A&E attendances and re-admissions for those patients that have experienced the Pulmonary Rehabilitation service; | | |
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| **Key Milestones** | March 2014 | Task and Finish Group Commences | |
| | July 2014 | Service Specification Complete | |
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