Ashford Clinical Commissioning Group

# Strategic Commissioning Plan

# April 2014- March 2019

## (Incl. Operational Plan April 2014-March 2016)

## v0.5

# Contents

## Sustainability

Provider Market
Capacity and Demand
Allocation Assumptions
2 Year Financial Plan
Expenditure Assumptions
Innovation Forum & Challenge Events
Clinical Leadership in Commissioning for GP Trainees

## Governance

Patient and Public Involvement
Delivery Architecture
Decommissioning and Disinvestment
Conflict of Interest
Complaints and Compliments
Freedom of Information
Equality and Diversity

## Introduction

The NHS has changed, with responsibility for planning and paying for local health services being transferred from Primary Care Trusts (PCT) to Clinical Commissioning Groups (CCGs). We have thought long and hard about how we can use these reforms to improve the health of the community we serve, by capitalising on our knowledge and understanding of the local population. We have concluded that there are two key components to ensuring that Ashford Clinical Commissioning Group (CCG) achieves its objective – putting patients at the centre of our decisions, and working in partnership with other agencies, such as the borough council and Public Health.

Ashford Clinical Commissioning Group (ACCG) has a membership of 15 practices covering the whole of the Ashford district and is led by local GPs and senior healthcare managers. We inherited a local NHS which offers good services, in good facilities and delivers good outcomes for most people, but is often uncoordinated and this means that the right things for patients are not always the easiest things to do. We will continue to work with residents and organisations, including Kent County Council, Ashford Borough Council, providers of health and social care, and the voluntary and community sector.

The aim of our Strategic Commissioning Plan is to tell the end-to-end story about how we will move from assessing the needs of our population to delivering services that will drive improvements in health outcomes. This document also sets out how ACCG will inform and involve residents, partners, health and social care professionals, and voluntary and community sector groups to ensure we champion their needs, and ensure their thoughts shape our decisions.

Some of the decisions we will have to make this year and next will be tough, but we know that together with local doctors, nurses, NHS staff and you, our patients and our public, we can make a real difference to the quality of services you receive and the NHS is able to offer. In all we do, we want to ensure patients are involved and can have their say. In establishing our channels for engaging the public we are taking the best of the past and incorporating it into exciting new engagement models, including using new technologies to help us create a social movement for improved healthcare.

Within the Ashford area I believe will have a healthcare partnership to be proud of, and I look forward to continuing the progress we have already begun to make.

We want a health economy that is sustainable for the future with primary and community care services working closer together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities

Increased elective productivity through provision of "Right care, first time, right place"

Integrated 24/7 urgent care system across all sectors

Reduced acute ambulatory care sensitive emergency admissions

Improved maternity experience particularly early pregnancy

Reduce the number of suicides

Personalised care and independent living for patients with long term needs

Enable patient-centric care to be delivered in the most appropriate setting

**Planned Care**
- Transform Outpatient Services
- Revised outcome based Orthopaedic Pathways

**Urgent Care**
- Falls Prevention
- Integrated Urgent Care Centre
- Ambulatory Care
- Out-Of-Hours GP Service
- Improved discharge planning

**Maternity & Children**
- Improved Early Pregnancy Unit
- Multi-agency intensive support team model for children with severe challenging behaviour

**Mental Health**
- All Age ADHD and Eating Disorder Services
- Personality Disorder Peer Support
- Crisis support

**Long Term Conditions**
- Community Geriatrician Service
- Integrated Diabetes Pathway
- Personal Health Budgets
- Earlier diagnosis of dementia

**Governance**
- Kent Health and Wellbeing Board
- Programme Boards for Urgent and Planned Care
- Corporate Governance Structure
- Monthly review of programme or project progress at CCG Clinical Strategy and Investment Committee meetings
- Identified Leads CCG for specific projects

**Success Criteria**
- Primary and community care services will work closer together, along with voluntary organisations and other independent sector organisations reducing the time people currently spend waiting for a service.
- We will see less acute admissions and reduced length of stay.
- We will see more people remaining in their own homes and a reduction in the proportion of the population living in care homes.
- More people will be living independently following reablement/intermediate care

**Values and Principles**
- People are supported to live in their own homes or communities.
- We have a workforce with skills to deliver integrated care.
- Our integrated teams respond rapidly to people at risk of admission
- 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

# About the CCG

## Background and Context

The Health and Social Care Act (2012) gave more power and responsibility to front-line professionals to commission safe, high-quality and compassionate care and to make decisions about the use of resources through Clinical Commissioning Groups. This comes at a time when, across England, the NHS must continue its QIPP programme to deliver £30bn of savings by 2020. We have started to build a track record of delivering change and have established a strong partnership approach in our local health and social care economy

This means that the next five years (2014-19) will be another challenging period for the NHS and your local CCG who will be supporting the delivery of the improvements and standards set out in the NHS Constitution, the NHS Mandate and the NHS Outcomes Framework.

In support of the 2014/19 planning and delivery process the CCG has produced this document to:

- Provide the context in which the CCG operates
- Communicate our plan to our patients and local population
- Mobilise commissioners, providers, partners, voluntary organisations and members around a common set of objectives and plans
- Provide assurance on how we will deliver what the CCG aims to achieve

The document and content within it is generated from, amongst other inputs, demographic information, performance data, national guidance and recent health inquiries. However, one of our most important sources of information is that which our patients and public provide us directly. We have used a number of stakeholder events, feedback given to our practices and our formalised patient participation groups to inform this plan and we will continue to refine and update our plans based on what our patients and public are telling us.

We believe that these steps will deliver ambitious improvements to the local NHS in line with the needs of local people as set out in our Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy as well as against the 5 Domains of the NHS Outcomes Framework:

| | |
|---|---|
| Domain 1 | Preventing people from dying prematurely |
| Domain 2 | Enhancing quality of life for people with long-term conditions |
| Domain 3 | Helping people to recover from episodes of ill health or following injury |
| Domain 4 | Ensuring that people have a positive experience of care |
| Domain 5 | Treating and caring for people in a safe environment and protecting them from avoidable harm |

This plan is owned and sponsored by our governing body and member practices and represents our commissioning and delivery intentions.

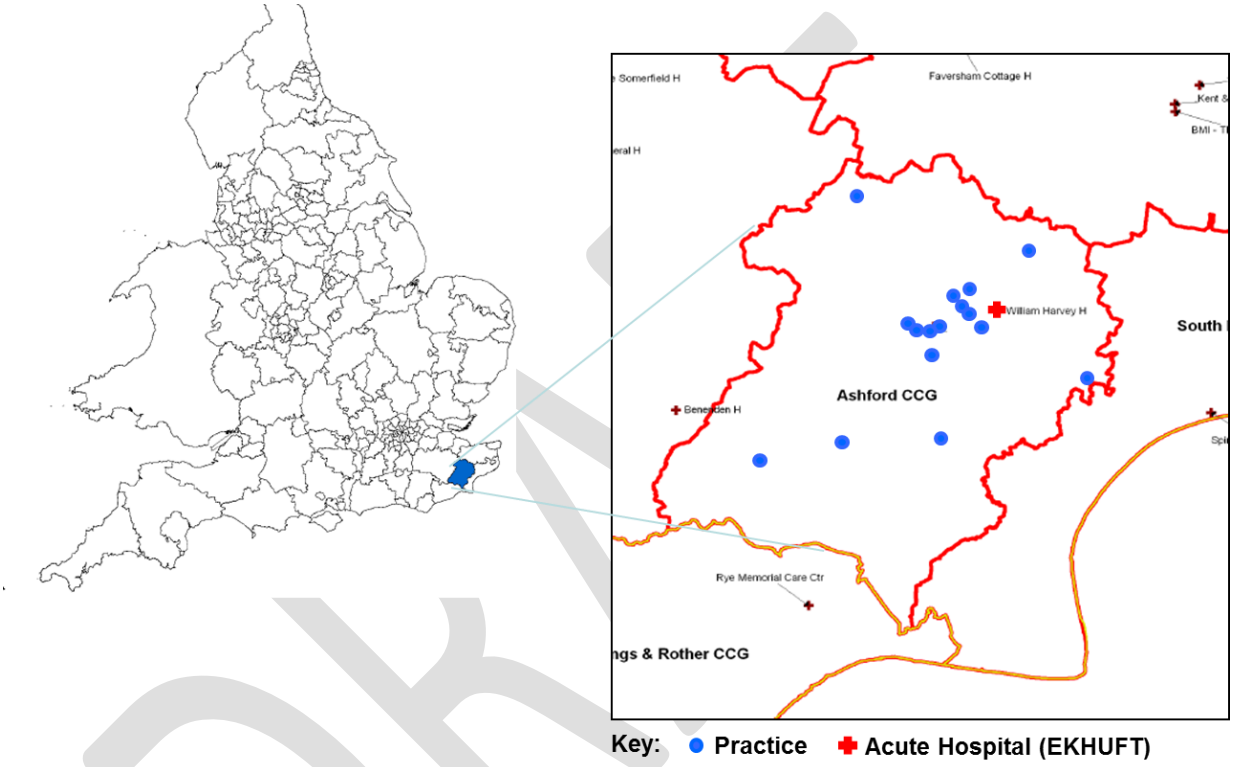
## Joint Strategic Needs Assessment

| SUMMARY – OUR POPULATION HEALTH CHALLENGES | |
|---|---|
| | |
| **Inequalities** | The average life expectancy in Ashford is 83.4 years for females compared to males at 80.7<br><br>The lowest life expectancy figures are in the wards of St Michaels and Weald East and Weald North, with the highest figures in Park Farm North and Washford. The difference in the number of years between the highest and lowest life expectancy at birth is 15.7 years. |
| **Population** | The resident population of Ashford comprises approximately 120,116 (ONS, mid-year estimates 2012). In comparison to England, Ashford has a considerably smaller proportion of 20 to 34 year olds and a larger proportion of 40-49 and 60+ year olds.<br><br>The distribution of the Ashford CCG population means that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the "ageing population time bomb". The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth. |
| **Cause of Death** | Circulatory Disease is now the main cause of death (34% of deaths), followed by Cancer (26%), and respiratory disease (15%). |
| **Lifestyles** | Smoking leads to cardiovascular disease, respiratory disease and cancer. NICE highlight that smoking is the "leading cause of health inequalities in the UK today and the principal reason for inequalities in death rates between rich and poor." In Ashford, almost 35% of people in the most deprived wards are smokers which compares to less than 20% in more affluent wards.<br><br>The prevalence of adult obesity has been mapped across electoral wards in Ashford. The wards with the highest prevalence (estimated to be between 26% and 30%) are Beaver, Stanhope, Norman and Aylesford Green. All these four wards are found in the south of Ashford town and have a relatively high level of deprivation. |
| **Long-Term Conditions** | There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions. |
| **Mental health** | Age specific adult mental health rates are seen to correlate with areas of deprivation, with high rates seen in Stanhope, Beaver, Norman, South Willesborough, Aylesford Green and Victoria Wards. Lowest rates are seem in Weald North. |
| **Dementia** | Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65. |

The information in this section provides the geographical, socio-economical, regulatory and financial context in which NHS Ashford CCG will commission services in 2013/14. It directly informs what NHS Ashford CCG will prioritise within the context of limited resources.

## Location

The geographical area covered by NHS Ashford Clinical Commissioning Group is fully coterminous with Ashford Borough Council:




## Key High-Level Data

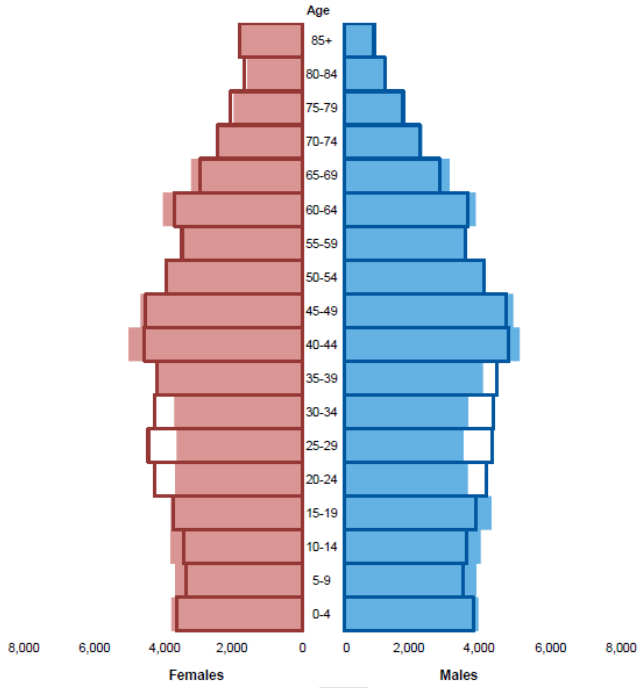
Below are some high-level data points which are relevant to this CCG and its commissioning activity:

| Data Point | Data |
|---|---|
| Registered patient population: | 122,000 |
| Number of GP practices: | 15 |
| Neighbouring CCGs | 4 |
| Acute Hospital | 1 |
| Commissioning budget: | £134.5M |

## High-level demographic information

The chart below shows the number of people registered with this CCG's practices by sex and 5-year age band. The darker outline shows the profile of England's population.

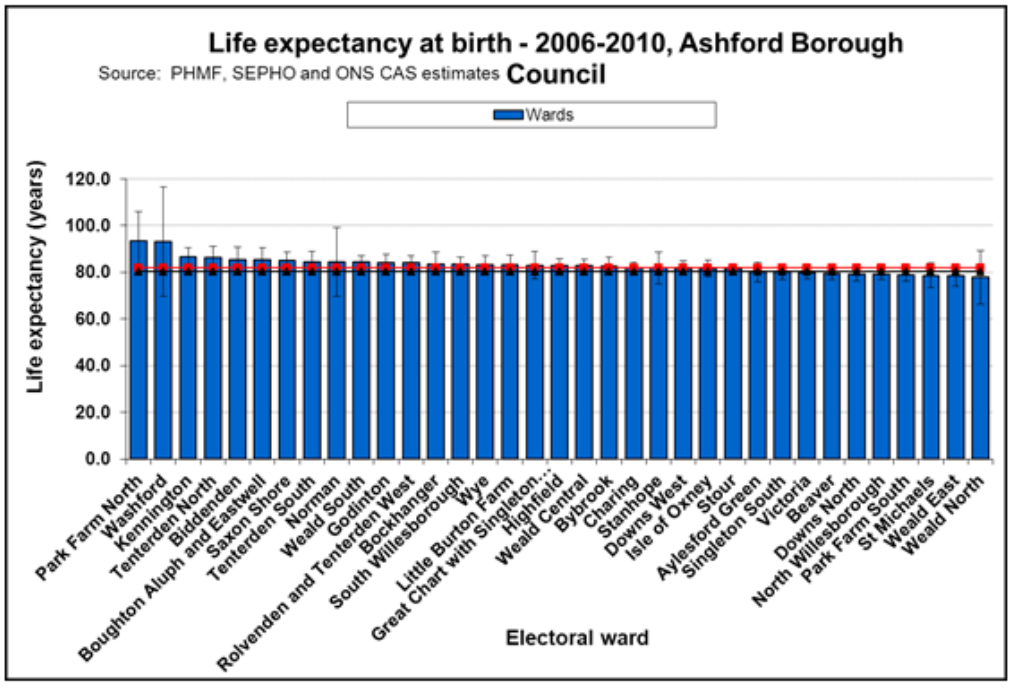
Compared to the rest of England, Ashford has a higher than average population between the ages of 5-14, 40-49 and 60-69. Alongside the importance of health promotion and prevention for the younger generation ACCG must also plan for a 16% rise in 65+ age groups.




More generally, the town of Ashford is set to double in size over the next 25 years. As new housing developments emerge, ACCG will work with Ashford Borough Council to ensure that these new populations benefit from high quality, local integrated health and social care services.

### Life Expectancy

Compared to the eastern and coastal Kent average ( the line in black), the average life expectancy for Ashford ( the line in red) is high i.e. 80 vs 82:

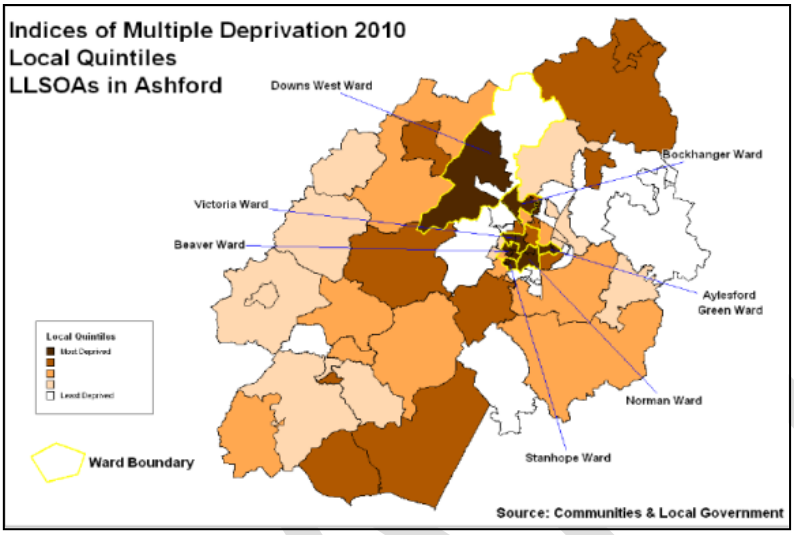



However, whilst ACCG is proud of its current health outcomes it recognises it will need to work hard to maintain the health status and clinical effectiveness of its population particularly with the

expected growth in the 65+ population. Additionally, whilst the life expectancy is higher than local averages, Ashford also contains the biggest variation in life expectancy across its wards in Kent and Medway. All of our project and programmes must therefore include, as an objective, the targeting of those communities which do not benefit from the outcomes that the majority of our population currently experience. This includes educative elements across all of our projects and programmes.

### Deprivation

Whilst the ACCG benefits from relatively good health outcomes and life expectancy it does include some relatively deprived wards denoted by the dark brown areas on the map below.




The 20% most deprived areas of Ashford are in the central and southern parts of the town (Stanhope, Aylesford Green, Norman, and Beaver), although the village of Hothfield in the Downs West ward and Bockhanger were also in the worst quintile for deprivation.

Inequalities in health are primarily a socio-economic relationship. The poorer people are, the greater the likelihood of early onset disability and chronic disease and shorter life span. In contrast, those who are of high status have expectations of a much greater disability free life span and of a good old age.

People with low socio-economic status are at greater risk of behaviours causing ill health. They will have higher smoking rates, have a poorer diet, have less opportunity to take part in social activities, have poor mental health. Whilst it is undeniable that individual behaviour is a significant driver of ill health, it is wrong to attribute all causes of premature poor health and early death to personal behaviour. If such behaviour was eliminated, people with the lowest socio-economic status would certainly live longer, but would continue to die prematurely relative to the mainstream society.

Addressing health inequalities as a strategic response requires CCGs to commit to partnership working with other statutory agencies whose capacity to address the wider determinants of health is core to their purpose. Accordingly ACCG must support the actions of Public Health working with local authorities to address the root causes of disadvantage through the Kent Health Inequalities Strategy and more locally through the work of Ashford's local Health and Wellbeing Board. All pathways must include education as a key step to mitigate the risk of individual's behaviours affecting their health.

## Working across CCGs

In some instances, CCGs need to work together to create a bigger footprint as a "unit of planning" in order to effectively commission some of the services for which they are responsible, but also to share risk safely, transfer skills and secure commissioning support. The CCGs in east Kent have agreed to collaborate in a range of areas where working together will;

- **Support Clinical Improvement –** through consistent, evidence based pathway development and effective and consistent performance management
- **Drive greater efficiency –** by ensuring leverage with providers; keeping transaction costs low; and sharing (potentially scarce) expertise and capacity
- **Provide greater resilience –** by managing financial risks together; improving risk management and sustaining more effective business continuity arrangements

A range of initiatives have been agreed which will ensure that CCGs are able to work together across east Kent to both deliver transformation in areas where a greater critical mass must be achieved to make change sustainable and where wider approaches are key levers to improvements in individual CCGs.

As illustrated in the diagram below the projects will be planned and delivered at either an East Kent-level, as joint projects with Canterbury and Coastal CCG or as a local project only to serve Ashford CCG's needs:


## Ashford Health and Wellbeing Board

The Ashford Health and Wellbeing Board brings together the statutory and voluntary organisations which are involved in healthcare, social care and public health to champion the delivery of better, more efficient and integrated services in the area. It is a forum where partners can share their respective objectives, performance requirements and proposed plans with a view to identifying areas of mutual interest and support. Although formally a sub-committee of the Kent board, the local board is closer to local citizens/patients and has a more detailed insight into their needs and preferences which therefore complements the county-wide overview and is able to inform and influence County priorities and actions

The Board can review spending plans and priorities of the constituent partners e.g. public health, district and county council and CCG and their contribution to health and wellbeing and informs priority setting, commissioning decisions and the planning process

# System Vision

## Our Vision

Our vision and goals within our plan have not been developed in isolation and reflect the broader strategic context in which we operate as a statutory body. There are a number of external factors and influences, plus national requirements on which we are mandated to deliver. These can be broadly encapsulated in the following analysis.

| Political | Economic |
|---|---|
| • National policy implementation<br>• Changing NHS landscape<br>• Secretary of States mandate<br>• Public Health Transition<br>• Legislative changes<br>• Regulatory bodies<br>• Market development<br>• NHS England<br>• Healthwatch<br>• Health & Wellbeing Board<br>• Professional preferences and resistance | • Financial sustainability<br>• Financial Accountability<br>• QIPP Challenge<br>• Financial climate<br>• Patient choice<br>• NHS Cooperation and Competition<br>• Foundation Trust pipeline |
| **Social** | **Technological** |
| • Health inequalities<br>• Deprivation factors<br>• Equity of Access<br>• Lifestyle choices<br>• Ethical decisions<br>• Protected characteristics | • NICE guidance<br>• Evidence based decisions<br>• IMT providers and suppliers<br>• Emerging technology<br>• Introduction of new drugs<br>• Use of social media and internet |

ACCG worked on our mission, vision and strategic priorities as it went through its authorisation process to become a statutory commissioning body. They were arrived at through consultation with our patients, members and Governing Body. They are also aligned to, and informed by, the Kent Health and Wellbeing Strategy.

**"A Healthcare Partnership to be proud of"**

To improve the health and well-being of the population of Ashford by successfully engaging local GPs to lead our work and working in partnership with patients, Ashford Borough Council, Public Health and other key stakeholders, to develop plans to improve outcomes.

## Community Based Care

There is no lack of ambition to deliver the right outcomes for our patients and the wider population but we recognise the unprecedented scale of the challenge that faces the NHS nationally and locally. However, we believe that our developing plans give us the building blocks for a sustainable health economy in east Kent.

We have sufficient evidence for us to adopt radical change across the local health economy, drive improvements in medicines use and by working in partnership with our members, improve Primary Care infrastructure, workforce and services for patients.

We are confident that we are doing the right things for both patient care and for the delivery of a sustainable, viable and vibrant health economy, where we will actively seek and support opportunities for integrated care and integration between health and social care.

We are convinced that maintaining and driving the types of improvement to the quality of services set out in this plan will drive the productivity which delivers long term sustainability.

The fundamental, underlying, principle which reaches across all of the following domains is that the CCG are keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations –including their own home, their pharmacy, the optometrist, their GP surgery as well as district hospitals.

Our patients and carers should expect a high quality, compassionate, safe and personal service based around their needs, present and future. They should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services.

The focus on quality must be our first consideration. Patients should not come to harm as a result of accessing and receiving care and we will commission services which deliver the best possible clinical outcomes within the available resources.

As part of this, we will move towards affordable 24/7 services, which are integrated across health service providers with voluntary and social services incorporated into community-based contracts. To enable this we will use new contract mechanisms (e.g.: alliance, lead provider), for defined geographical locations and which have clear, explicit, measurable outcomes for defined cohorts of patients

## Primary Care

Whilst NHS England have responsibility for commissioning GP services through the national GMS and PMS contracts, general practice delivers significantly more services than ten years ago and this trend will continue with a proportion of this additional work transferred from traditional community or hospital bases. Excellent General Practice is core to the delivery of Ashford CCGs strategic vision.

In order for this is be possible a number of changes in the way which general practice operates will need to occur. NHS England has set out a call to action to staff, public and politicians to help the NHS meet future demands, including those faced by GPs. As a CCG we are supporting our practices as they endeavour to reconfigure their approach in response to this call.

Ultimately we anticipate that the outcome of this longer term approach will mean larger or federated practices offering more services, including Social Care, acting as the central hub for a wider variety of services and with improved access for traditional GP services.

## Urgent Care

People using services and their carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need. Many patients, through better preventative care, should not need to access urgent care services. In addition patients often experience issues in identifying the best urgent care option to suit their needs. Furthermore, once they access urgent care services they may find it difficult to be discharged quickly and effectively due to sub-optimal integration of care services.

Traditional models of Urgent Care services have often been described as being highly fragmented and generate confusion among patients about how and when to access care. The Kings Fund report "Transforming our health care system" identifies a number of common issues across Urgent Care:

- Patients are frequently admitted to Hospital when it is not clinically justified because of a lack of alternative available options
- Poor sharing of information as patients move between different providers is a cause of significant failures of care (Ghandi, 2005)
- The growth of new forms of Urgent Care, such as walk in centres has failed to reduce A&E attendances (Cooke et al, 2004)
- New forms of urgent care have also failed to reduce Emergency Admissions, which continue to grow, rising by 5% between 2008/9 and 2011/12 (Department of Health 2011d; 2012).

An activity analysis of the patients who attend A&E has suggested locally that 38% of patients attend A&E present with Primary Care conditions. Provider organisations across East Kent recognise that patients attend A&E for a variety of reasons including:

- Health care Services are fragmented and difficult to understand
- Services in and out of hours offer different levels of cover
- A&E is recognised as a one stop shop service

It has long been recognised within east Kent that integrating services will reduce the amount of duplication and improve speed and ease of access for patients. Following the integration and roll out of several significant initiatives within the area, the east Kent health economy is proposing a fully integrated Urgent Care service. This has been designed by all providers in East Kent as one project.

The proposed model will bring services together to ensure that care will achieve a number of goals including a rapid multi-disciplinary assessment with 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. This service will prevent a significant cohort of patients from having to attend hospital , improve recovery following an event and ensure that patients retain independence.

It will achieve this by providing rapid access to key health economy services which include:

- General Practitioners
- Community Support Services
- Social Services
- Psychiatric Services
- Secondary Care Consultants (including Geriatricians)

A variety of apparently isolated service developments are in fact drawn together leading to the colocation of a number of key services within hubs across East Kent under a single command and control structure to create a multi-disciplinary team working as an Integrated Urgent Care Centre (IUCC).

These centres are about the colocation of services around specific buildings to provide an immediate multi-disciplinary response to self-presenting patients and also the coordination of a number of services which together form east Kent response to increasing demands. Our collective vision provides rapid access to care for a greater cohort of patients complimented with enhanced local support services for patients on a 24/7 basis. This will significantly reduce conveyances to hospital and provide enhanced care and support for patients to help them recover in their own home or place of residence.

## Long Term Conditions

Our approach to the management of patients with long term health and social needs, also links with our vision for urgent care and our community based approach. The number of patients with long term needs is expected to rise due to an ageing population and certain lifestyle choices that people make.

We will continue our current approach of identifying patients requiring additional support through risk profiling. Risk stratification tools are utilised to support the identification of patients at risk and GPs are working locally with community nurses and members of the integrated health and social care teams (locally referred to as Cluster Teams) to ensure Management Care Plans are developed to support and educate patients to manage their own conditions.

Previously, a patient may have received visits from a number of community teams and GPs would have to refer patients to a variety of organisations depending on the patients' needs. The approach means patients only have to tell their health story once, and GPs only need to refer a patient to one team through a health and social care coordinator. As previously stated a key component of this is to ensure that the cluster teams are based in and around towns in the area, and aim to provide a more integrated health and social care service and work closely with the patient's GP to ensure patients receive the right services and support quickly to avoid an unnecessary admission to hospital.

## Children and Young People

As our health profile demonstrates, Ashford CCG will see significant growth in the child population during the next 7 years, however some of the largest increases will fall within the 0-4 age range, creating significant demands on paediatric services.

National research states that the use of A&E departments by children is often not for emergency care but the default position for concerned parents, or just sometimes the nearest centre of care. In essence this demonstrates a need for us to improve access to paediatric services that can be provided in primary care, children's centres and other community settings to reduce unnecessary and avoidable admissions to Secondary Care and to ensure that parents are supported within their own communities.

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. This approach is supported by national research and best practice in relation to developing a whole system approach to improving emergency and urgent care for children, young people and their families.

The current system within Ashford CCG area is disjointed and parent carers have also stated that it is confusing and difficult to navigate. There are a range of access points within the health system for children, young people and their families including GP practice, minor injuries, A&E, Short Stay Paediatric Assessment Unit and out of hours, community children's nursing service, health visiting service and school nursing service. Through Ashford CCG patient and public engagement events there is also a demand to access services closer to home in the community, rather than always in a

hospital setting. A new whole system approach between providers of healthcare (and for those with more complex needs providers of health, education and social care) is required to ensure services are more streamlined and provide seamless care which will lead to better outcomes.

We will align our paediatric transformation programme, and whole system approach for urgent and emergency care for children and young people, with the wider transformation programmes outlined above to maximise impact and promote effective transition to adult services.

## Planned Care

Referral rates from GPs have reduced in the past number of years, with waiting times also consistently reducing. In order to ensure that waiting times reduction is maintained, as demands increase, we need to continue to consider alternative approaches to GP referral.

With this in mind analysis has shown that a number of patients are discharged from secondary care immediately following their first outpatient appointment. One of the reasons for this is that the GP is seeking additional advice on the management of a patient's condition, and for a number of these patients attending the outpatient department offers little real value.

GP's and other health professionals who refer patients to acute services will have access to acute care consultants via a mechanism that will be fast and easy to access by all involved. Currently there are schemes in place, and have been piloted previously, that utilise either Choose & Book (eBooking) or secure email (Nhs.net)

The objective is to formulate the exact mechanism which is acceptable to all uses and will provide outcomes of appropriate referral, first time for patients which will in turn also result in reduced referrals as some patients disease management will be better undertaken in primary/community care

Our patients also tell us that they are inconvenienced by a system which requires them to attend for outpatients, then separately for diagnostics, then again for follow-up. Not only is this inconvenience for them but it's not effective use of resources. Repeated visits are often clinically unnecessary and lead to increased anxiety for patients. In addition the capacity used leads to delays in the system for the delivery of 18 weeks.

Nationally 37 million follow up appointments where patients are asked to return to hospital to have their progress checked, to undergo tests, or to get test results. 75% of all out patient 'Did Not Attends' (DNA) are for follow-up appointments. The follow-up DNA rate varies between specialties and locations but a range of 10-40% is common. There are more than four million follow-up DNA's per annum, which cost the NHS more than £100 million a year.

With waiting times for diagnostics dropping significantly over the past few years, there is no longer the requirement for patients to attend outpatients, return for a diagnostic test and then return to outpatients for the results and treatment plan.

One Stop Services facilitate the assessment, diagnosis and commencement of treatment plan within one visit. Across our local health providers there are limited services where a one stop approach is undertaken. This results in the need for patients to make several visits to the provider before they commence treatment.

In order to ensure that providers are able to deliver one stop services it will be necessary to support the redesign of outpatient services particularly in relation to provision of same day diagnostics. Therefore it is anticipated that this project will take at least 15 months from commencement to completion across all specialties

Whilst East Kent Hospitals University NHS Foundation Trust undertake the majority of outpatient services the project will require working with all providers to ensure that there is consistent approach and therefore equity of care. The CCG is committed to working with the organisations who provide planned care services to improve care and to look at different ways of ensuring high quality services that are centred on the patient and are available as close to their home as possible.

## Mental Health

The majority of people with mental health needs in the Ashford CCG area are looked after by their GP. Where patients need more intensive support, they are predominantly treated in services provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

We will continue to promote good mental health and wellbeing in the community, reduce the number of people who get common mental health problems, and lessen the stigma and discrimination associated with mental ill-health. We will ensure that prevention is targeted at those at higher risk but also that the right services are there when people need them.

Public services, the voluntary sector, and the independent sector will work together to improve mental health and wellbeing. Services will be personalised, will involve service users and their families in equal partnership, will aid recovery and will help people to reintegrate into their communities. They will promote the best care and promote accessible, supportive and empowering relationships. As with the CCG's underlying principle, wherever possible, services will be community-based and close to where people live.

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. We will reduce the number of suicides. We will ensure that 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. We will ensure that all people using services are offered a service personal to them, giving them more choice and control. We will deliver better recovery outcomes for more people using services with care at home as the norm. We will ensure that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service.

## Working with Social Care – The Better Care Fund

Kent is an Integrated Care and Support Pioneer – providers from across the health and social care economy are partners and stakeholders in the Pioneer programme and were involved in developing the blueprint for the integration plans which the Better Care Fund (BCF) is based upon. The Integration Pioneer Working Group who produced the Kent plan is a mixed group of commissioners and lead providers.

As part of the development of the BCF plan engagement events have taken place with providers via our existing Health and Social Care Integration Programme, the Integration Pioneer Steering Group and through a facilitated engagement event led by the Health and Wellbeing Board under the Health and Social Care system leadership programme.

- Together we will design and commission new systems and models of care that ensures the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

- We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.

- The Kent Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated Commissioning will be achieving the shift from spend and activity in acute and residential care to community services, underpinned by JSNA, Year of Care financial model and risk stratification. We will have a locally agreed tariff system across health and social care commissioning.

- A proactive model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community / primary / secondary care interfaces will become integrated.

- We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors. We will also need to ensure that we link in with our partners within education

- An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will have overcome information governance issues. Patient held records and shared care plans will be commonplace.

- We will systematise self-care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

The Kent Health and Wellbeing Strategy has identified key performance measures, these are currently being updated and will include measures for integration. In addition there are local measures in place against existing projects which will support the BCF projects. As a Pioneer Kent will be undertaking a baseline assessment and delivering against the performance measures set out by the Programme. These will be combined with the metrics as outlined in the Better Care Fund plan to produce a robust performance and outcomes framework.

## Centres of Excellence

To be completed with detail from NHS England Specialised Commissioning

## Cancer Services

To be completed with input from NHS England Specialised Commissioning

## Cardiovascular

To be completed with input from NHS England Specialised Commissioning

# Delivering Harm Free Care

**Berwick, Francis and Winterbourne**
**Quality Monitoring**
**Hospital Acquired Infections**
**Never Events**
**Whistleblowing**
**Safeguarding**
**Patient Experience**
**Additional Quality Priorities**

## Berwick, Francis and Winterbourne Reviews

We will ensure that the recommendations from the Winterbourne View, Berwick and Francis reports are implemented within all local health providers and for ourselves as commissioners. We will have an additional focus on monitoring safer staffing levels throughout provider organisations and through contractual processes.

## Quality Monitoring

We will work with our providers and use the contractual levers available to ensure that patients are treated in a safe environment, with an emphasis on zero tolerance of avoidable harm and ensuring that nursing care is of the highest standard;

We will ensure that systems are in place to monitor potential breaches of safety and improvements against the NHS Safety Thermometer, particularly in relation to pressure area care. We will ensure that provider organisations comply with national guidance in relation to the reporting of incidents to ensure that system wide learning can then be undertaken.

## Hospital Acquired 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.

## Never Events

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.

## Safeguarding

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

We will continue to maximise opportunities for greater coordination and integration of adult and children's safeguarding arrangements

We will work with NHS England to ensure the recruitment of GP leads for safeguarding

We will work collaboratively to ensure the sharing and implementation of learning from serious case reviews and audits across the health community

We will continue to ensure that the continuing healthcare service is compliant with all national standards whilst retaining a focus on the quality of care being delivered.

## Patient Experience

We will work with providers to put mechanisms in place to systematically gather real-time patient and carer feedback including ensuring the Friends and Family Test is in place across all providers.

We will continue to use real-time feedback from our patients and carers and build on this to assess the experience of people who receive care and treatment from a range of providers in a coordinated care package across health and social care.

## Additional Quality Priorities

- The continued elimination of mixed sex accommodation and increased dignity for patients

- full implementation of the NICE quality standards and the implementation of root cause analysis of any Venous Thromboembolism (VTE) occurrences
- reducing harm to patients, particularly pressure ulcers
- improve safety within maternity services

## Performance

**Contractual and Performance Management**
**Provider Development**
**CQUIN payments**
**Care Quality Commission**
**Friends and Family Test**
**Infection Control**
**Mixed Sex Accommodation**
**'Never Events'**
**Serious Untoward Incidents**
**NHS Constitution Standards**
**Waiting Times**

## Contractual and Performance Management

There has been an increased focus on provider performance management in 2013/14 and this will continue into 2014/16.

Our approach to management of the Hospital contract will focus around improving patient outcomes whilst achieving National Targets – for example 18 and 52 week referral to treatment times and ensuring compliance with all cancer waiting standards.

For community services we are one year through a two year contract and we will focus on establishing service lines within the scope of the vast community contract which can be independently monitored as part of the contracting process. For example, establishing a baseline for community nursing services and ensuring that for the money we spend we are getting enough of the right nursing services for our population.

The Mental Health contract will be moving from a Kent Wide commissioning arrangement to an East Kent contract to enable us to focus more closely on delivery of appropriate care for patients within this area. There will also be progress towards payment by results tariffs for Mental Health over the coming year moving us from historic block arrangements to a cost per case mechanism for payment.

## Provider Development

There are 130 contracts which the CCG is a party too and we are undertaking a plan for systematically ensuring all of these are up to date and are properly monitored in relation to outcomes for patients but also to ensure appropriate amounts of activity are undertaken for the best possible value. The majority of the contracts are small but important services which contribute to the overall strategy outlined in this document of ensuring we can provide the most appropriate care setting.

The overarching approach to developing contracts for 2014-15 the CCG has taken account of:

- Improvement in Care of Patients especially the frail elderly,
- Avoidance of duplication and achievement of timeliness of care,
- The need to work within the funding available.

## CQUIN payments

All NHS contracts must include a Commissioning for Quality and Innovation (CQUIN) payment which is a payment of 2.5% of contract value over the contract baseline which is payable as an incentive for innovative working.

For 2014-15 the CCG has identified areas to start making the change. It is likely that quality payments will be made to providers through the strategic use of the CQUIN arrangements covering the following areas:

- Chronic Obstructive Pulmonary Disorders (COPD)
- Diabetes
- Heart Failure
- Dementia

These quality payments will be linked to whole system outcome and process measures wherever possible. This will require providers to work together to drive change. Quality payments will not be made where one provider is successful but overall patient care does not improve. So we will attempt to put the same measurements into all contracts for the next year to ensure that the Hospital works with Community services or that Mental Health and Acute services are aligned and properly incentivised to deliver the best outcomes for the patients.

## Care Quality Commission

The CQC has launched their new Intelligent Monitoring report. This replaces the Quality Risk Profile (QRP). The new model monitors a range of key indicators about NHS acute and specialist hospitals. The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements but will be backed up by inspection. Each indicator has been analysed to identify two possible levels of risk ("risk" and "elevated risk").

East Kent Hospitals University NHS Foundation Trust (EKHUFT)were rated as a Band 3 organisation (the bands are 1-6 with 1 being the highest risk). There were four areas assessed at EKHUFT as showing an 'elevated' risk. These were:

- Mortality following hemi-arthroplasty repair of a fractured neck of femur - HMSR 125
- Patient experience and functional outcome following elective knee arthroplasty (PROMs)
- Response rate against the Friends and Family test
- Educational concerns reported to the CQC by the General Medical Council (GMC)

The CQC has subsequently written to EKHUFT with details of their forthcoming inspection. The CQC's inspection will start on 3 March 2014. The core site visit is likely to last between two and five days. Inspections take around two weeks in total, but this includes the CQC's team preparation day and any follow up work they will need to do. Within this ten day envelope, the CQC will spend around two to three days on site with a large team inspecting the eight key service areas. The CQC may add services to this depending on their assessment of risk and the number of acute sites. The CQC will be allocating leads to the inspection teams who will be the primary CQC contacts over the weeks running up to the inspection.

## Friends and Family Test

The Friends and Family Test (FFT) aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients. Nationally, Trusts are measured using the Net Promoter Score (NPS) where a score of approximately 50 is deemed good.

EKHUFT's NPS was 64 in October, thus demonstrating overall satisfaction with Trust services. The company, 'iWantGreatCare', which reports FFT data on behalf of EKHUFT have converted the NPS into a "star score" value (ranging from 0 to 5) thus making the interpretation of FFT results easier. The star score is calculated using an arithmetic mean, so a ward that scores 4 stars has an overall average rating of "likely" to be recommended. EKHUFT score for October was 4.6 stars out of 5 stars.

EKHUFT is achieving the overall response rate for F&F with inpatients but not A&E. The use of texting within A&E indicates improved response rates. Early indications for maternity, suggests low response rates. The recovery plan continues to be delivered, overseen by the Task and Finish Group.

## Infection Control

There was one Trust assigned MRSA case in November which brings the YTD total to 7. There was one case of C.difficile (post 72 hours), during November 2013 bringing the YTD total to 36 against a year end trajectory of 29 cases. A comprehensive recovery plan is in place to ensure EKHUFT is providing adequate prevention, screening and appropriate treatment at all times, particularly around identifying patients requiring a stool specimen on admission. Public Health England has been invited to undertake an external review of the C. difficile control programme and this took place on 20 Nov-13.

Enhanced vigilance is being applied to infection prevention and control procedures given the current Trust performance against Department of Health targets. The Infection Prevention and Control Team (IPCT) use routine surveillance and the findings of Root Cause Analysis (RCA) and Post Infection Review meetings for MRSA bacteraemia and C.difficile cases to inform subsequent actions in providing support and challenge to wards and departments. Particular focus currently relates to antibiotic prescribing which is being audited. Clinical reviews of all inpatients with MRSA are being undertaken by the IPCT, which includes checking compliance with Trust policies in relation to the patient's management. The recently revised 'Diarrhoea Assessment Tool' has been introduced and is being applied in the management of all cases of diarrhoea. In addition enhanced surveillance of cleanliness standards in each of the sites is in progress. Site based briefings have taken place to emphasis adherence to policy.

Mandatory training performance for Infection Control is 85.2% Trust wide for October, against a 95% target. This remains a steady percentage, although the Divisions are working to action plans to improve the percentage. To date these action plans have not been received from EKHUFT.

## Mixed Sex Accommodation

A performance notice has been issued to EKHUFT confirming that any previous agreement with the PCTs around the reporting of mixed sex accommodation breaches in CDU is no longer recognised, and that the national guidance clearly states that CDU is not exempt. In October 2013, there were 7 mixed sex breaches at WHH, 6 of which occurred in CDU, and 1 in the Richard Stevens Unit (RSU), affecting a total of 43 patients. None of these were reported by EKHUFT nationally to NHS England on the Unify2 system.

## 'Never Events'

One new Never Event has been reported in November 2013 for EKHUFT, this relates to a NG tube being misplaced which resulted in the patient death a few days later. Investigation is currently in progress.

EKHUFT have 4 on-going never events. These relate to 1 wrong site surgery, 1 incorrect chest aspiration, 1 retained swab post C-section, and 1 misplaced NG tube.

## Serious Untoward Incidents

### East Kent Hospitals University NHS Trust

EKHUFT has reported 3 Serious Incidents for the month of November, 2 at Kent and Canterbury, and 1 at William Harvey Hospital. All 3 have been categorised as Unexpected deaths. 1 was a mis-placed NG tube, and as such classified as a Never Event, one was a post-op Aortic Aneurysm patient, and 1 was a fall resulting in a head injury which led to the patient's death. This fall occurred in October, but was not reported until November, and is believed to relate to the severe harm fall reported in the October board paper by EKHUFT. There was also a lack of clarity as it was categorised as an unexpected death, rather than a Slip/Trip of fall, which was the cause of the head injury. EKHUFT is awaiting the decision on the primary cause of death from the Coroner, and further information will be provided when the Root cause and analysis are received.

2 Grade 2 serious incidents were reported in November 2013, the 72 hour reports were received in deadline maintaining 100% compliance.

### Kent Community Health NHS Trust

During the month of November 2013, 4 new SIs were reported by KCHT. This consisted of 1 allegation against a HC non-professional, 2 confidential information leaks, and 1 drug incident.

One grade 2 serious incident has been reported in November 2013, a 72 hour report has been received in deadline maintaining 100% compliance as per the previous month.

### Kent and Medway NHS Partnership Trust

During the month of November 2013 there were 6 SIs reported by KMPT , which is a slight decrease from the 7 reported in October, and a clear decrease from the 10 in September, 15 in August and 24 in July.

Overall, the majority of on-going KMPT serious incidents occur in patients' homes and public places. These two locations account for 57% of the on-going SIs for KMPT i.e. 25 of the 44 on-going serious incidents reported by the Trust.

Suicide by Outpatient (in receipt) is the highest category of on-going SIs for KMPT, with 34% of the total falling into this category. There is no apparent trend with regards to the area of Kent or team the clients were being treated by. Absconds are second highest with 23% of on-going KMPT SIs being attributed to this category. The highest number of these occurred at Medway Maritime Hospital, 4 in total, with 3 occurring on Sapphire Ward.

Despite absconds continuing to be one of the highest on-going categories in KMPT; there has been a decrease in their occurrence. Work is underway within KMPT to ensure that there is better management of Section 17 leave to try to avoid clients absconding when unescorted. Further agreement has also been reached between KMPT and West Kent CCG on which absconds are to be reported, as a number do not result in any harm to the patient who is returned within a matter of hours.

During November 2013, no Grade 2 SIs were reported.

### South East Coast Ambulance NHS Trust

During November 2013 4 new SIs were reported; 2 (50%) were reported within the two working days deadline and 2 (50%) between 5-10 working days There were no Grade 2 SIs reported during November 2013.

## NHS Constitution Standards

To be completed

## Waiting Times

### 52-week

There has been a further reduction in the number of patients waiting more than 52 weeks for treatment, with 4 recorded as of end of October compared to 10 the previous month.

The Divisional Director for Surgical Services has confirmed that EKHUFT have an agreed action plan following the contract query notice which the CCGs have accepted. There is an agreed reduction trajectory in place which indicates that the backlog will be cleared by the end of December and details how this will be sustained going forward.

Despite the continuously improving position, it was confirmed in the month 5 contract performance letter that the appropriate breach penalties will continue to be applied until such times as the number of patients waiting beyond 52 weeks reaches zero. KMCS and the CCGs will monitor performance against the agreed reduction trajectory according to the contract query notice issued.

### 4 Hour A&E Waits

EKHUFT has been struggling to achieve the 95% target for A&E 4 hour waits since April 2013 and have failed to meet the target for the second successive month, achieving only 92.71% in October. Despite this EKHUFT have managed to meet the 95% target for both Q1 and Q2, achieving 95.2% and 95.1% respectively and have therefore avoided any contractual penalties.

EKHUFT have identified a series of key challenges they believe have all contributed to the difficulties seen in achieving this target, and have detailed what actions are being undertaken in respect of each of them.

### Cancer Waits

The current unvalidated position for October shows compliance across all standards with the exception of 31 day drug treatments, which is currently shown at 96.55% against the 98% target. EKHUFT reported that it had 1 patient breach against this target in October. The patient had to undergo a day surgery procedure to allow access for chemotherapy to be administered, which resulted in an extended pathway for the patient.

It has been identified that EKHUFT failed the 93% target for Q2 for the 2 week wait for symptomatic breast cancer standard, achieving only 88%. The consequence of this breach is '2% of revenue derived from the provision of the locally defined service line in the quarter of the under-achievement'. IPM has requested in the month 6 contract performance letter that EKHUFT detail what remedial actions have been put in place to address this issue and the trajectory by which EKHUFT hopes to maintain compliance. The CCGs have requested that EKHUFT present this update at the next contract performance meeting and would consider withholding the contractual penalty depending on how comprehensive an action plan has been developed.

Following non-compliance in both August and September, the 2 week wait for symptomatic breast cancer standard has returned to a compliant position for October, with unverified figures showing 93.75% against the target of 93%. EKHUFT report that this is as a result of rapid access referrals increasing significantly to cope with the additional demand.

For those tumour groups not meeting the relevant standard in October, each tumour site specialty has an action plan in place to address the issues and help deliver an improvement in performance. These action plans are being reviewed at Divisional Director and Divisional Medical Director level at monthly Cancer Compliance meetings.

## Sustainability

**Provider Market**
**Capacity and Demand**
**Allocation Assumptions**
**2 Year Financial Plan**
**Expenditure Assumptions**
**Innovation Forum & Challenge Events**
**Clinical Leadership in Commissioning for GP Trainees**

## Provider Market

Ashford CCG commissions services from a wide range of providers with provision well distributed across the patch. Quality and performance are good but not consistent across all providers. There is an increasingly diverse provider market but the local geography and poor transport links can limit the willingness and ability of people to travel to receive care.

In addition to a number of GP practices, across the Ashford locality, who offer a wide range of services over and above their obligations under the GMS/PMS, detailed below are our main providers by area of care:

General Acute:

- East Kent Hospitals University Foundation Trust
- Medway NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust

Community:

- Kent Community NHS Trust
- ic24 ( Out of Hours)

Mental Health:

- Kent and Medway NHS and Social Care Partnership NHS Trust
- South London and Maudsley NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust

Independent Sector:

- BMI Chaucer Hospital
- Spires Healthcare
- Benenden Hospital

The CCG are keen to work in partnership with major provider to ensure that we can protect essential services for our local population. However, we expect to see a shift towards more integration between provider and an increase in health and social care community providers. Within that context we will develop a local market where there in only a plurality of providers where appropriate and where that doesn't undermine the underlying system vision of integrated services for our patients.

In any provider market we wish to develop an environment conducive to high quality training, for *all* providers, which ensures that our patients will receive the highest quality of care both clinically and non-clinically.

## Capacity and Demand

To be completed

Any Town CCG Analysis

## Allocation Assumptions

The CCG is currently assuming a 20% move towards the new allocations formula. Although it is not known how much this will actually equate to, due to speed of implementation, it is felt that planning at this level is appropriately risk averse.

## 2 Year Financial Plan

Set out below is the expected allocation and expenditure for 2014/15 and 2015/16.

| | 2014/2015 | 2015/2016 |
|---|---|---|
| Final 13/14 Allocation | £130,093,000 | £129,880,403 |
| Less Non Recurrent Allocations | -£1,434,000 | |
| 2% Allocation Growth | £2,573,180 | £2,467,728 |
| CCG Funding for ITF | -£385,977 | -£3,896,412 |
| Assumption on Pace of Change for Allocations | -£965,800 | -£965,800 |
| Recurrent Baseline | £129,880,403 | £127,485,919 |
| Return of Surplus | £1,345,400 | £1,342,358 |
| £25 per head Running costs | £3,010,000 | £2,709,000 |
| Total Non-Recurrent Allocation | £134,235,803 | £131,537,277 |
| 13/14 Forecast | £130,802,779 | £128,037,703 |
| Full Year Effect Issues (inc recurrent QIPP) | -£453,156 | -£1,610,192 |
| Non-Recurrent Spend | -£589,170 | £0 |
| Cost Pressures | £1,148,603 | £1,174,633 |
| 1.5% Population Growth | £1,917,186 | £1,920,566 |
| 1.6% Reduction in Tariff | -£2,044,999 | -£2,048,603 |
| QIPP | -£6,440,769 | -£3,436,665 |
| CQuin Impact | £844,718 | £844,718 |
| Expected 14/15 Programme Spend | £125,185,192 | £124,882,158 |
| £25 per head Running Costs | £3,010,000 | £2,709,000 |
| 1.5% Non-Recurrent Transition Funding | £2,013,537 | £1,315,373 |
| 1% Further Funding for ITF | £1,342,358 | £0 |
| 1% Contingency | £1,342,358 | £1,315,373 |
| 1% Surplus Requirement | £1,342,358 | £1,315,373 |
| Total Spend | £134,235,803 | £131,537,277 |

## Expenditure Assumptions

The start point for the planning is the 13/14 forecast out-turn position. The CCG is on target to make its surplus but has had to use all of the 1% contingency and the 2% strategic change funding to support this position. This is due to a number of factors including those within and external to the CCGs control. 13/14 QIPP delivery has not been as expected, a major contributor to the current position. For some areas of expenditure, for example prescribing despite QIPP delivery the position has been adversely affected by changes in Category M pricing and other factors.

The Full Year effect adjustments include both QIPP investment and savings expected to continue from the 13/14 financial year.

The adjustment for non-recurrent funding reflects the fact that the CCG will no longer receive is reablement funding. As reablement funding has been used to deliver a number of joint projects across the health economy a resultant cost pressure has been included in the plan to reflect the need for a proportion of this funding going forward.

Cost pressures include growth allocated to those areas recognised in the planning guidelines as expecting price inflation. Additionally the CCG is undertaking significant developments across some of the larger East Kent contracts moving to payment based on real usage rather than fair share to allow better commissioning decision making. Finally a significant cost pressure determined nationally is the move Payment by Results for mental health although these values are yet to be finalised.

Population Growth is expected to be at 1.5% and tariff has been reduced as advised in the guidance.

The total QIPP amount included in the plan equates to £7.0m, comprised of £0.3m schemes to be continued and £6.7m of new commissioning plans. This equates to 5.3% of the total budget. In 13/14 the 3% planned level of QIPP was recognised as significantly challenging and one of the highest plans in the region. The CCG recognises that the level of QIPP in the 14/15 plan exceeds this by 2.3% and represents a significant challenge that can only be delivered through fundamental changes in delivery of healthcare across providers, that is facilitated by utilisation of all contracting options available to commissioners.

The creation of the ITF fund included in the 2014/15 plans is assumed as a cost to the CCG, with no financial benefit in year through reductions in activity in the acute setting, this will need to be discussed with our Social Care Partners.

The plan also assumes that there will be 1.5% strategic funding available and a further 1% for the ITF (described below). As required the plan also assumes 1% contingency and 1% surplus. No additional funding has been assumed at this time for savings in primary care and any quality premium.

Running costs will be at the expected level of £25 per head of population.

The challenge is further compounded in 2015/16 as the full impact of the ITF is included and the expected resource growth reduces. However, in year 2 of the two year plan a number of the more substantial integrated service models will be implemented or part implemented, thus generating the major change needed to sustainably move the CCG to an affordable baseline.

The challenge therefore for the CCG is to deliver the very challenging significant QIPP target in 2014/15 before the large integrated system changes impact in 2015/16.

## Innovation Forum

The NHS is currently faced with quality, efficiency and demand challenges on a scale that has never been seen before. Organisations across the NHS have already made significant progress in reducing delays, improving quality, and giving patients access to new services and technologies. However, in order to respond effectively to the scale of the current challenge, all parts of the health and care system will need to collaborate to apply innovative approaches to the problems they face.

Innovation, Health and Wealth (DH, 2011) defines innovation as:

> *"An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied"*

This gives clinical commissioners the dual role of championing the adoption of innovation and best practice seen elsewhere, alongside seeking to generate new ideas and ways to apply new opportunities creatively.

In recognition of this, NHS organisations now have a "duty to innovate". The commitment to champion innovation was included as part of the CCG authorisation process.

Together with Ashford CCG we have established an Innovation Forum, through which we can:

- Generate new ideas
- Learn about best practice opportunities
- Agree new ways to address complex priority areas

The objectives of doing this are to:

- Accelerate the identification, adoption and diffusion of innovations that will improve patient outcomes and service quality in areas that the CCG defines as priorities
- Embed innovation into the CCGs' commissioning cycles
- Build an innovation climate within the CCGs and partner organisations
- Link with other organisations involved in health and care (commissioners and providers) so that they can also embed innovation and innovation projects in their business planning processes

The Innovation Forum brings together senior CCG decision makers along with agreed relevant external input from the academic community, technology industry and health and social care stakeholders. Participants are asked in advance to consider specific questions or focus areas, and to identify relevant information, research or case studies based on their own experience or areas of work. This also involves considering how existing practice or tools could be applied differently or in other areas. The aim of the Innovation Forum is not to carry out an in-depth review of opportunities, but to consider how they might impact on the health challenges that the group prioritises.

## Innovation Challenge Events

Twice yearly an Innovation Challenge event will be run, bringing together a wider group of people to learn about opportunities in a particular area and consider how they will be applied for local people. Each Innovation Challenge event will have its own objectives, which will vary according on the questions being posed, however events will have a number of objectives in common:

| Learn and challenge | Generate ideas |
|---|---|
| • Increase understanding of the presenting issue from different perspectives<br>• Hear about alternative solutions (or components of solutions) from providers and users<br>• Learn about what has worked – and what hasn't – in other areas<br>• Consider why the approach in place locally does not fully meet the needs of service users | • Consider how new approaches or tools would impact the presenting issue<br>• Discuss how existing tools (new or already in use in the area) could be improved<br>• Review what could be done differently to address gaps in services<br>• Learn from how other organisations or industries are addressing similar challenges<br>• Probe the ideas considered: do they fully address the presenting issue or is there a way to enhance them further? |
| **Agree actions** | **Synthesise solutions** |
| • Agree what should be taken forward and how<br>• Define specific actions and owners<br>• Understand what inputs are required to make each action happen<br>• Ensure clarity over who's leading on different solution areas<br>• Confirm expectations of stakeholders | • Identify groups of linked opportunities<br>• Prioritise the ideas raised<br>• Gauge interest and consensus from different stakeholders<br>• Gain stakeholder commitment to being involved in developing the opportunity from idea/pilot to broader diffusion |

The first Innovation Challenge Day was held in April, focussing on Dementia. Working with the Young Foundation, the event was attended by commissioners and provider organisations, local authority, third sector organisations, universities, and technology firms.

Our aim was to think differently and hear different things about ways to support people with dementia. Speakers presented on their innovative tools or services supporting different aspects of dementia care. Small group discussion to help review, understand or prioritise the innovative ideas presented. Participants were asked to identify ways in which they would take back the ideas generated and use them to influence change in their own organisations.

It is important to differentiate between an Innovation Challenge event and a patient co-design or consultation event. People who use services should be involved to raise their alternative perspectives of services and their ideas about what could make them better, as well as ensuring that the group understands the potential impact of opportunities. However, Innovation Challenge events should be focused on opportunities to deliver transformational change benefiting a large number of people, rather than redesigning elements of specific services in detail. A project initiated at an Innovation Challenge event could lead to a number of other engagement events during the development and delivery period.

## Clinical Leadership in Commissioning for GP Trainees

The GP Clinical Leadership in Commissioning (CLIC) rotation is an innovative or integrative GP training post (ITP). ITPs and have been used for a number of years, and have been a feature of many areas in Kent, Surrey and Sussex. Educationally, they are an extension of the educational placement for trainees that are a regular part of the GP placement (such as attending an outpatient clinic, community clinic, or public health department). Previously, they have consisted of a combination of GP Trainer employed and hosted posts, or part placement (and employment) in a GP Training Practice and part placement in a hospital or community clinic post.

The commissioning rotation comprises 5 clinical sessions within a GP practice and 2 days within the commissioning setting. Most trainees will work on a Wednesday and Thursday within the commissioning component of the rotation, with the other five clinical sessions in GP. Mandatory sessions are structured with experts in areas of commissioning or workshops which relate to key aspects of leadership development. Each trainee is allocated a commissioning project which they work on alongside the CCG commissioning team.

Trainees are expected to demonstrate evidence of learning, teaching and team working as part of RCGP curriculum requirements and personal professional development. In this placement the trainees are invited to present to their supervisors and peers at the end of the 4m placement.

# Governance

Patient and Public Involvement
Delivery Architecture
Decommissioning and Disinvestment
Conflict of Interest
Complaints and Compliments
Freedom of Information
Equality and Diversity

## Patient and Public Involvement

A communication and engagement strategy document has been developed to set out how Ashford CCG will inform and involve residents, partners, health and social care professionals, voluntary and community sector groups to ensure that specific health care needs that have been identified in the Joint Strategic Needs Assessment are addressed. This document is to be found on the website:

www.ashfordccg.nhs.uk/

In summary though, our main means of engaging patients and public include:

| Means of Engaging Patients and Public | Detail |
|---|---|
| **Patient participation groups (PPGs)** | Ashford's CCGs practices have a patient participation group. Representatives from the CCG attend these group meetings to listen and act on patient views. Ashford Patient Participation Group also attends (in a non-voting capacity) the CCG Governing Body |
| **Public reference group (PRG)** | Consists of a representative from the PPGs as well as representatives from key groups and organisations. |
| **Ashford Health Network** | Ashford CCG is looking to set up a virtual group of patients, members of the public and voluntary organisations who help make decisions about local health services. |
| **Ashford Health magazine** | Free quarterly health promotion magazine available online. To receive a hard copy of the magazine patients/public are able complete a form and send back using a freepost address. These are available in surgeries and other community venues. |
| **Governing Body meetings** | These are now held in public where people can contribute to the meeting agenda. |
| **Healthwatch Kent** | Healthwatch Kent will be run by a consortium of 'Kent and Medway Citizens Advice' (KAMCA), 'Voluntary Action within Kent' and 'Activmob'. The consortium aims to excel at providing advice and information to the public, supporting the voluntary sector, and engaging with the public in new and innovative ways. C&C CCG is looking forward to working with Healthwatch Kent as it continues to emerge in 2013. |
| **@AshfordHealth** | Twitter account for Ashford CCG with latest news, tips and advice for Ashford's local community |

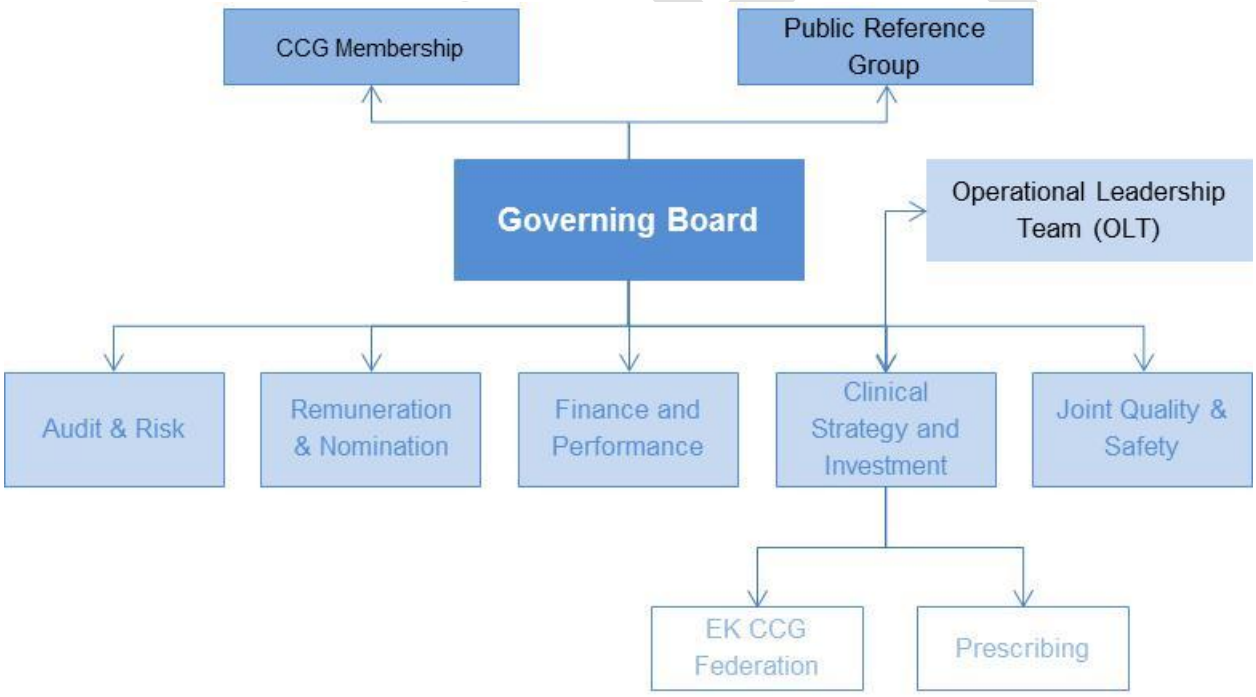
## Delivery Architecture

To ensure that Ashford CCG remains focused on delivery of its plans throughout 2014/16 and beyond it will implement the following tracking mechanisms.

- Monthly review of project progress at operational team meetings, run by the Head of Commissioning Delivery
- Monthly meetings between the Clinical Programme Lead and Commissioners
- Monthly review of programme or project progress at CCG clinical strategy committee meetings
- Monthly review of how the CCG is doing against its Quality Premium indicators

Where possible, the benefits of each project should be tracked to monitor its effectiveness in achieving its objectives. The aforementioned fora will be used to check whether benefits have been realised. If they have not been realised, a decision will be taken about whether the project continues or is adapted.

To support the on-going development and delivery of the Strategic Commissioning Plan, the CCG has developed the following governance structure.



## Decommissioning and Disinvestment

To ensure that limited resources are consistently directed to the highest priority areas the CCG have identified the need to develop a Decommissioning and Disinvestment Plan that sets out the agreed principles for decommissioning services to allow funds to be redirected where appropriate. There is a need to ensure that when approval has been given to decommission, or disinvest from, a service a clearly defined process is followed, with clear lines of accountability and responsibility.

> ***Decommissioning:*** *This relates to the withdrawal of funding from a provider organisation where the service is subsequently re-commissioned in a different format.*
>
> ***Disinvestment:*** *This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.*

In some circumstances there will be the need to re-commission part of the service or a modified service to ensure that there are no gaps in healthcare delivery.

The following points will be considered when making the decision to decommission a service.

- The patient experience and health need must be paramount and gaps in service provision minimised once the service ceases.
- The potential destabilising effect on other organisations e.g. third sector, of a decision to decommission/disinvest should be considered.

## Conflict of Interest

The CCG takes conflicts of interest very seriously. Ashford's constitution details how conflicts of interest will be managed but in summary:

Declarations of interest are published on the Ashford CCG website: www.ashfordccgnhs.uk

Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the Group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Head of Corporate Services.

The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

## Complaints and Compliments

Most medical care and treatment goes well, but things occasionally go wrong, and people may want to complain. They may want to make positive comments on the care and services that they or their family have received. These comments are just as important because they tell NHS organisations which factors are contributing to a good experience for patients.

We welcome complaints as a valuable means of receiving feedback on the services we commission for the people of Ashford and also on the way we go about our business. The CCG aims to use information gathered from complaints as a means of improving services and the effectiveness of the organisations. We seek to identify learning points that can be translated into positive action, and where necessary provide redress to set right any injustice that may have occurred.

Personal information may be anonymised for the purposes of monitoring the complaints process or improving service quality. The purposes for which identifiable information will be used is strictly for the processing of the complaint. This may include passing relevant information to a service provider in order that they can provide appropriate responses and comments on the circumstances set out in the complaint.

Patients and service users are encouraged to express complaints, concerns and views both positive and negative about the treatment and services they receive, in the knowledge that:

- they will be taken seriously
- they will receive a speedy and effective response by a member of staff appropriately qualified and trained to respond
- appropriate action will be taken
- lessons will be learnt and disseminated to staff accordingly
- there will be no adverse effects on their care or that of their families

We are committed to dealing with all complaints fairly and impartially and to providing a high quality service to complainants.

Complaints received by NHS Ashford CCG are investigated by Kent and Medway Commissioning Support (KMCS). KMCS is hosted by NHS England, and provides a number of administrative functions including managing the complaints process. This may involve accessing your case records and disclosing relevant information to the CCG in order that we can discharge our duties to you under the NHS Complaints Regulations.

## Freedom of Information (FoI)

The Freedom of Information Act 2000 (FOIA) came into force on 1 January 2005, and gives the public and other organisations the right of access to information held by NHS Ashford CCG. We are committed to openness and transparency in the conduct of all our business.

The Freedom of Information Act 2000 recognises that, gives the public and other organisations have the right to know how public services such as the NHS make their operational decisions and how public money is used. The Act gives anyone a general right to request access to see official information held by public authorities. The Act reflects a national policy to shift from a culture of confidentiality to one of openness, where information is routinely available, subject to certain exemptions, to anyone who wishes to see it.

Freedom of Information (FOI) requests are processed by Kent and Medway Commissioning Support (KMCS) on our behalf and we maintain a disclosure log on information that has already been published which is available through our website to download. However, if someone is unable to find what they are looking for on the publication scheme, then a written request should be sent to:

**Freedom of Information Team**
Kent House - 4th Floor
81 Station Road
Ashford
Kent
TN23 1PP
Email: foi@nhs.net

## Equality and Diversity

We fully recognise the importance of the Public Sector Equality Duty (PSED) and have already developed our Equality and Diversity Strategy which includes our equality objectives, set in line with the four Equality Delivery System (DH Toolkit) goals. These are detailed below:

| Goal | Narrative | Outcome |
|---|---|---|
| 1. Better health outcomes for all | The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results | 1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities<br>1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways<br>1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly<br>1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all<br>1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups |
| 2. Improved patient access and experience | The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience | 2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds<br>2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment<br>2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised<br>2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently |
| 3. Empowered, engaged and well-supported staff | The NHS should Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs | 3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades<br>3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay<br>3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately<br>3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all<br>3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.)<br>3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population |
| 4. Inclusive leadership at all levels | NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions | 4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond<br>4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination<br>4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes |

We will review these annually and ensure our staff are supported to commission services which ensure equality of access to services and that meet the needs of our diverse population.