NHS DGS CCG VISION & PRIORITIES (2014 – 2019)

Goals				
Focus on right care, right time, right place and right outcomes	Prioritising patients with greatest health needs & ensuring clinical evidence behind every decision	Maintain and Improve Quality	Provide strong clinical leadership across health &Social Care	Deliver a sustainable Health & Social Care System

Top Priorities

Op plan year 1 - QIPP	Op plan year 2 – QIPP	Op plan year 3/5 – QIPP DELIVERY £10.5M
Integrated Primary Care Teams with GP practices supporting proactive management of vulnerable patients	Procure and Implement integrated community model	Primary Care Strategy implementation
Integrated Discharge Team with DVH, KCHT, KCC and KMPT	Full implementation integrated discharge/ rapid response Team	Full Implementation of integrated community service model
Single Point of access and integrated rapid response service	Children's Community Nursing Model implementation	Review further clinical pathways and implement improved models of care-
Community Ophthalmology service procurement	Implement community Ophthalmology service	Implementation of new Urgent Care Centre 24/7 service (OOH/Walk in Centre/ MIU / NHS 111 service)
Clinical pathways reviews – paeds / T&O / repatriation	Urgent Care Centre (Out of Hours / Walk in Centre/ MIU, NHS 111) procurement	Implement all age autism / ASD pathways with KCC

Priority Initiatives

- (Yrs 1 & 2) Continuation of targeted preventative screening prioritising of CVD, cancer COPD and Obesity
- (Yrs 1 & 2) Integrated discharge Team inc. Elderly care direct access / Rapid response redesign with acute clinician support Community Services re-commissioned
- (yr1) Increase in Dementia nurses supporting patients in the community
- (Yr 2) Integrated community children's service
- Yr 1 Integrated Primary Care Teams with GP practices
- (Yr1&2) Integrated Health and Social care Single Point of Access
- (Yr 1) Mental Health – Urgent Care re-design / single point of access
- (Yr2) Community Ophthalmology service re-commissioned
- (Yr 1) Mental Health Primary MH Workers supporting patients
- (Yrs 1 & 2) CAMHs / YHM – single point of Access & CAF co-ordination
- (Yr2) End of Life Care /care Homes improved care
- (Yrs 1 & 2) Re-design & commission a Neuro-developmental all age pathway
- (Yr2) Pulmonary Rehab model procured
- (Yr 1) Clinical Pathway Review – paeds / T&O / re-patriation
- (Yr2) clinically agreed priorities
- (Yrs1& 2 OOH / Walk in Centre / MIU service re-commissioned
- (Yr1) Primary Care Strategy development
- (Yrs1& 2) Delivery of Medicines Optimisation strategy'

Health & Wellness - Primary Prevention and partnership working with Local Council Authorities in the HWBB and Public Health

Health & Wellness – Increasing Independence (self-care and carers)

Quality Improvements in all services including prescribing quality reviews with GP practices

Commissioning Innovation – use of technology to support sharing of clinical information to support patients care

- Whole System Transformational
- Service Improvement
- On-going Commissioning
- Enablers

Dartford, Gravesham and Swanley CCG Plan on a Page (2014 to 2019) TOP PRIORITIES

Our **Vision** is of primary, community, mental health and acute care services working seamlessly together , with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and communities and ensure a sustainable care economy.

Clinical Outcomes to be achieved

- •Rapid & appropriate investigation
- •Care in the most appropriate setting e.g. treating people at home or reducing stay in hospital
- •Improved safety & communication through patient records sharing
- * Proactive care planning (through co-ordinated multi-disciplinary care with social &MH needs)
- * Preventative care supporting patients to self manage their care

Objective One:
To reduce emergency admissions by 23.3% over 5 years

Objective Two:
To reduce the number of patients on the medically stable list to less than 30

Objective Three:
Increase the number of patients supported in the community by health and social care teams

Objective Four:
Increase the number of patients whose clinical records are available to all providers

Objective Five:
Increase the number of patients supported to maintain their independence (measured via Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /Rehabilitation services.)

Objective six:
90% of patients with dementia to have a multidisciplinary care plan

A streamlined common approach to advice and information on community and public sector services.

*This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the case;

*Providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised.

Coordinated and intelligence-led early identification and early intervention.

*Implementing community record and information sharing between the range of organisations supporting individuals at risk of requiring more support in the future.

*Ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved.

An improved approach to crisis management and recovery.

*Supporting rapid escalation and action when a crisis occurs in the life of an older person;

*A coordinated response from all agencies working in multi-disciplinary teams, 7 days a week, to provide intensive support in the short term and encompassing services such as respite care and supportive discharge planning.

*Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.

Integrated Primary Care Teams

*including acute physicians, community nursing and therapy, mental health and social care, resulting in non-elective admission reductions, care home and mental health placement reductions and ensuring patients with complex needs are managed in a “whole person” way.

*The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality and outcomes

*A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health needs.

*Tele-care and telemedicine will be more effectively used to support patients to be independent and they will be actively utilised in care homes with support to enable patients to be managed when in acute crisis.

*The core team would have strong working links with community support services using third sector providers such as the voluntary sector and District Councils to ensure full packages of care are provided to meet the needs of the patient, carers and the wider community.

Governance arrangements:

*Clear programme management plans managed by Local Programme Delivery Groups accountable to:

*Multiagency Executive Programme Board and CCG Board and Committee Structure & Supported by the DGS and Kent Health and Wellbeing Boards.

Measured using the following success criteria:

* By analysis of demand for acute health services (such as emergency bed days) and formal social care services (such as a paid agency carer supporting someone at home, or someone moving into residential or nursing care home),

* We will build on the Outcomes Framework which has been developed to support the CCG. This has a major focus on patient and carer experience, and triangulating data from several sources to measure outcomes.

Values and Principles:

* Keep people at the heart of everything we do, ensuring they are involved and listened to in the development of our plans
* Maximise independence by providing more integrated support at home and in the community and by empowering people to manage their own health and well-being
* Ensure the health and social care system works better for people, providing seamless, integrated care for patients, particularly those with complex needs
* Safeguard vital services, prioritising people with the greatest health needs and ensuring that there is clinical evidence behind every decision.
* Get the best possible outcomes within the resources we have available;