NHS Dartford Gravesham and Swanley CCG

Annual Operating Plan 2015/16 (Year two)

The Executive Summary

Introduction

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

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

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

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

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

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

Transformational change

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commissioning Intentions 2015/16

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

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

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

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

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

- Adult Community Services Review

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

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

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

QIPP 2015/16

The largest QIPP programmes in terms of financial gain are:

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

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

Financial Risks

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

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

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

Triangulation of Planning Returns

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

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

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

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

Governance and Delivery in 2014/15

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

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

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

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

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

Quality and Safety

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

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

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

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

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

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

BCF level of ambition for reducing NEL admissions

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

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

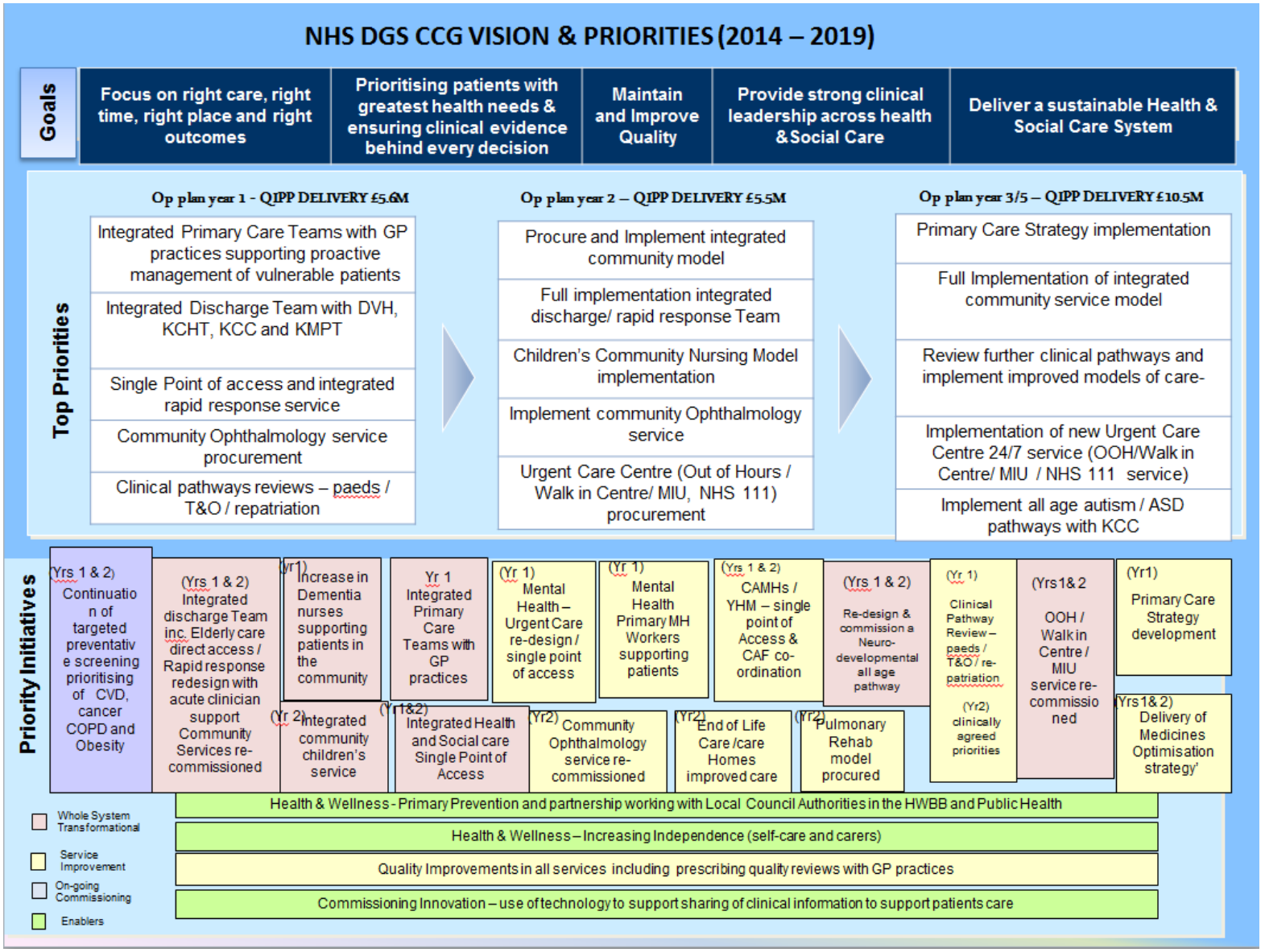
The Kent HWBB have agreed with all Kent based CCGs that the original ambition of 3.5% reduction in NEL admissions is not achievable due to the current significant demand on the acute system and DGS CCG has agreed a 0.8% NEL admission reduction target as part of the BCF (*Reference: DGS Strategic Commissioning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

Overview of CCG's internal operating plan assurance process

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

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

Appendix A DGS CCG Plan on a Page 2014/16



Appendix B – Details of the QIPP key projects

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

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

Appendix C – NHS DGS CCG Constitutional Performance and actions

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

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

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

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

Appendix D – Programme Summaries

Programme Area: Urgent Care and Long Term Conditions

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

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

What did our providers and GPs tell us?

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

What did our patients and local population tell us?

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

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

Programme Area: Urgent Care and Long Term Conditions

Risks and mitigating actions

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

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

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

Workforce implications:

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

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

Resource implications 2014/15:

Total planned net savings : £1,732,162

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

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

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

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

KPIs (link to national KPIs):

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

Reduction in non-elective admissions for targeted groups of patients

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

Reductions in emergency readmissions for targeted groups of patients

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

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

Improved use of alternative pathways

Additional KPIs are being developed for 2015/2016 commissioning plans

Programme Area: Planned Care and Cancer

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

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

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

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

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

Programme Area: Planned Care and Cancer

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

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

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

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

Programme Area: Promoting Wellbeing and Mental Health

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

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

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

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

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

Programme Area: Promoting Wellbeing and Mental Health

Risks and mitigating actions:

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

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

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

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

Workforce implications:

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

Resource implications:

2014/15:

Achieved net savings £80,370

2015/16:

Planned net savings £354,807k

KPIs (including link to national KPIs):

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

Enhance quality of life for people with long term conditions

Proportion of people feeling supported to manage their condition

Improving people's experience of integrated care

Additional for 2015-16:

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

Programme Area: Integrated Commissioning - Dementia / LD

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

Key Drivers for Change:

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

What did our providers and GPs tell us?

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

What did our patients and local population tell us?

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

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

Programme Area: Integrated Commissioning - Dementia / LD

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

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

Resource implications:

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

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

Programme Area: Children and Young People

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

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

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

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

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

Programme Area: Children and Young People

Risks and mitigating actions:

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

Workforce implications:

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

Resource implications:
2015/16:

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

KPIs (link to national KPIs)

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

Programme Area: Health Inequalities and Primary Care

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

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

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

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

Key projects and milestones:

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

Programme Area: Health Inequalities and Primary Care

Risks and mitigating actions:

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

Workforce implications:

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

Resource and activity implications 2014/15:

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

KPIs (link to national KPIs):

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

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

Programme Area: Prescribing

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

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

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

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

Key projects and milestones:

Quality

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

Innovation

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

Productivity

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

Prevention

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

Programme Area: Prescribing

Risks and mitigating actions:

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

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

Resource implications 2015/16:

In process of being calculated

KPIs (link to national KPIs):

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