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

Welcome

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

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

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

Dr Darren Cocker
Clinical Chair

Hazel Carpenter
Accountable Officer

Our Vision

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

NHS South Kent Coast CCG Strategy and Plan

Understanding Our Local Health Needs in 2015/16

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

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

NHS Outcomes

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

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

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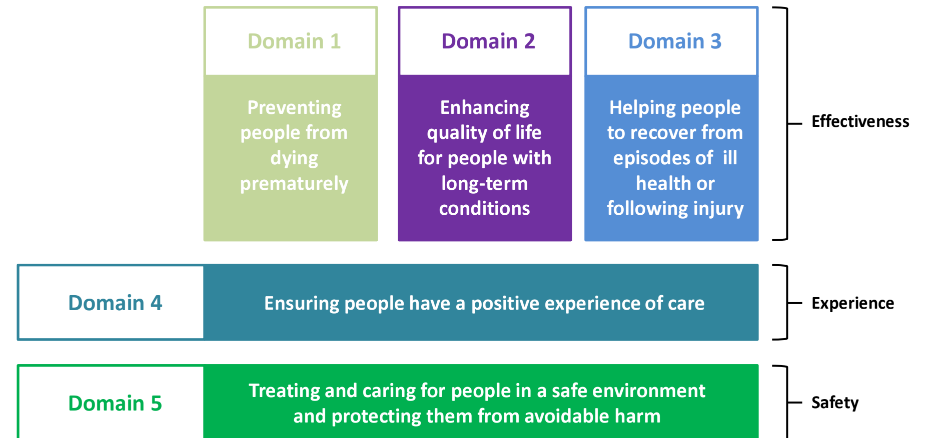

Figure 1

Our Commissioning plans for 2015/16

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

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

Out of Hospital:

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

In Hospital:

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

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Delivery of Improved Outcomes

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

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

Delivery of Improved Outcomes cont.

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

Our approach to contracting in 2015/16

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

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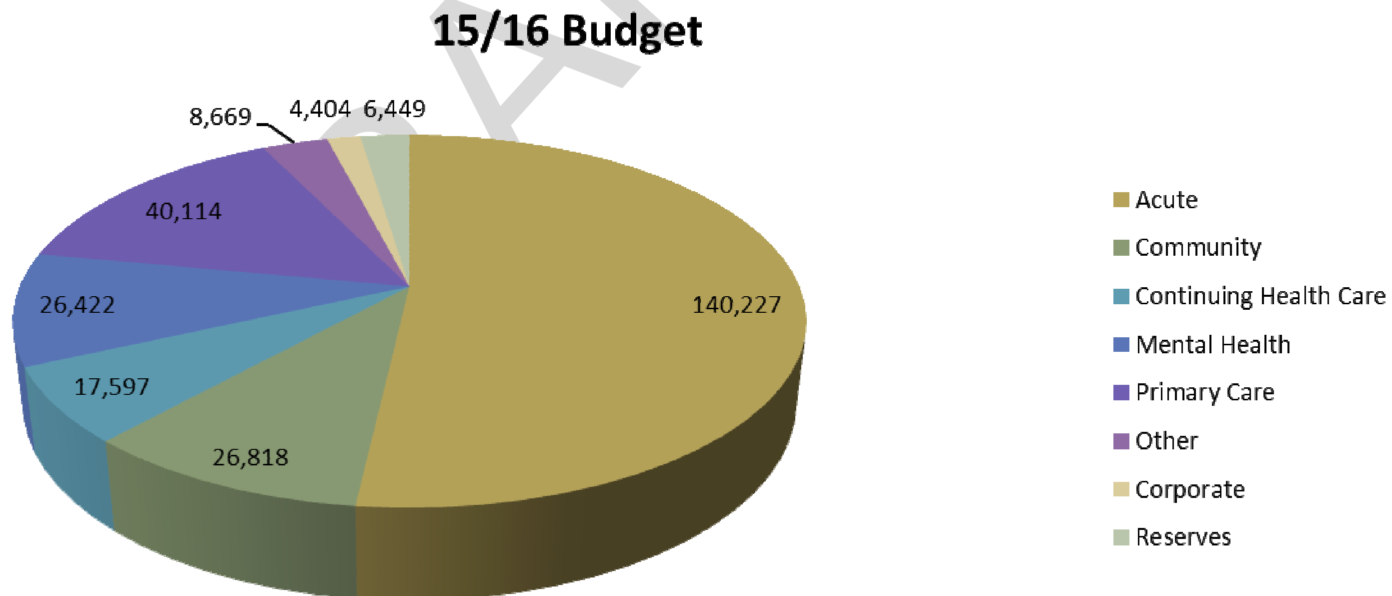
Our financial approach in 2015/16

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

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

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



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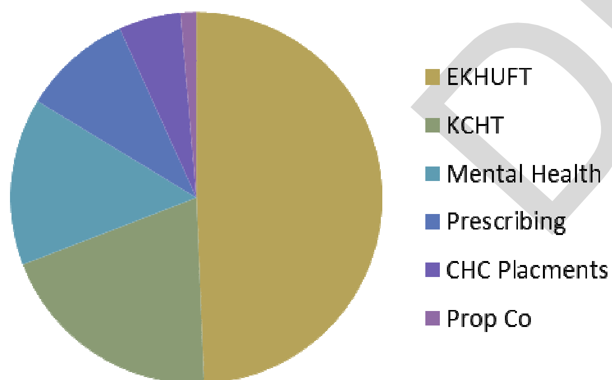
Our financial approach in 2015/16

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

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

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



Other QIPP areas:

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

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

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

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Our approach to improving quality in 2015/16

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

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

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

Francis Report

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

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

Berwick Report

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

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

Winterbourne Report

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

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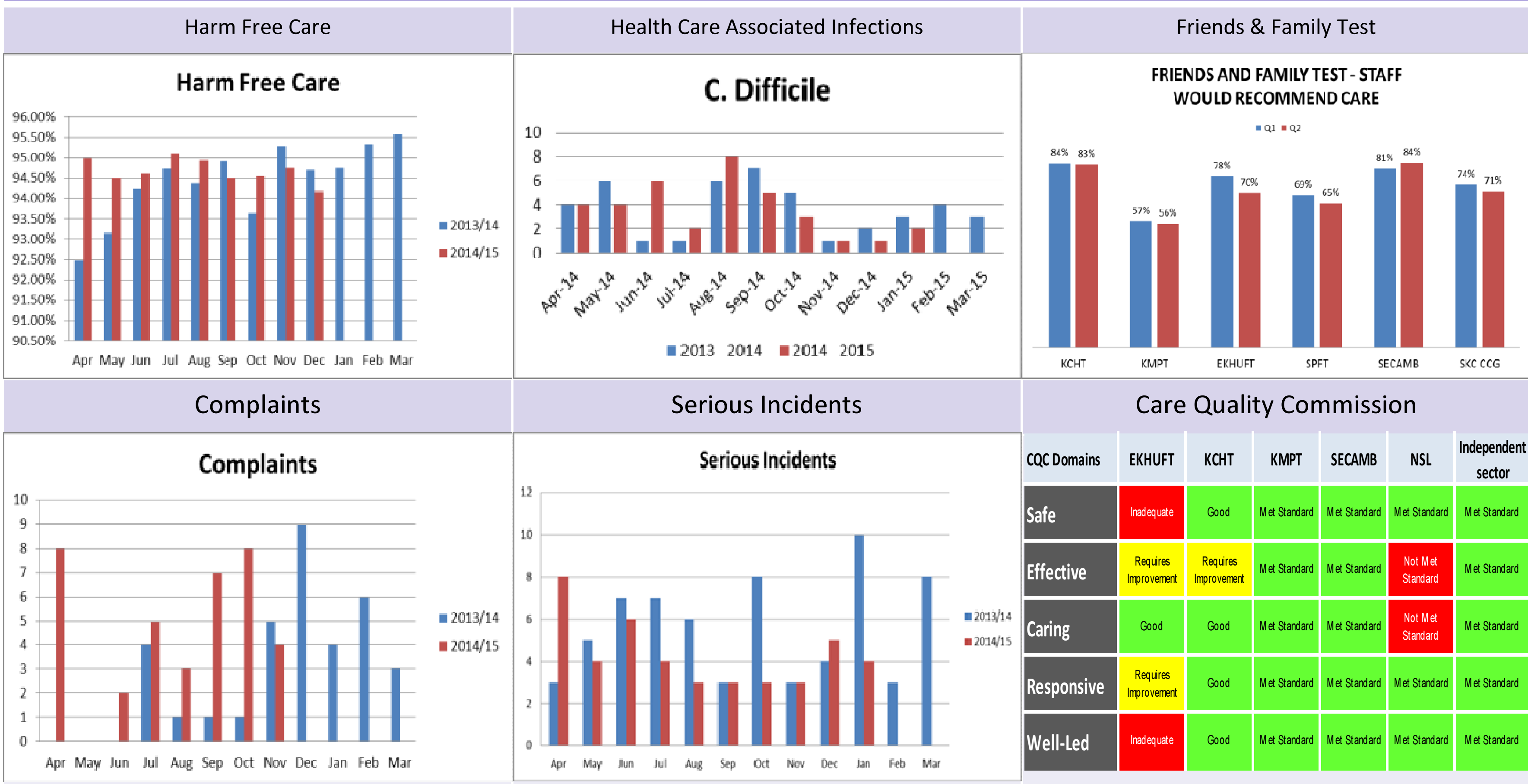
Our approach to improving quality in 2015/16

How the CCG Measure Quality

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

QUALITY METRICS



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

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

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

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

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

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

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

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

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

Out of Hospital Programme

From:	By doing what:	To:

From:

‘The professionals involved in my care do not appear to communicate with one another. I have to repeat my story every time.’

‘I do not know who the main person in charge of my care is.’

‘When I was discharged from hospital to my home, I was not clear on what would happen next.’

‘I panic when my condition deteriorates. I do not know who to contact.’

‘The care and support I receive has made me dependent on others. I feel no longer able to live my life independently.’

By doing what:

SYSTEM CHANGES

- The development of four Multi-specialty Community Provider ‘hubs’ (underpinned by an application to the *New Models of Care Programme*) offering specialist advice and support, including urgent and planned care responses, in:
  - Deal
  - Dover
  - Folkestone
  - Romney Marsh (including Hythe) (see model page 18)
- The development of multi-disciplinary integrated working at General Practice level - including social care and mental health - to improve management of patients longer terms needs in a proactive way. This will include promoting prevention, self-care and self-management and extend to enhanced support for patients in care homes;
- Further mobilisation of the Medical Interoperability Gateway (M.I.G) to ensure access to patients’ GP records across multiple providers (with patient consent) to avoid duplication and improving care for patients by enabling them to tell providers ‘once’;
- Mobilisation of community assets to ensure reaching as much of the population possible via District councils, domiciliary care agencies and voluntary organisations;

To:

‘The professionals involved with me talked to each other. I could see that they worked as a team’

‘I had one first point of contact. They understood both me and my condition(s). I could go to them with questions at any time.’

‘When I moved between services or settings, there was a plan in place for what happened next.’

‘I had systems in place so that I could get help at an early stage to avoid a crisis’

Taken together, my care and support helped me live the life I want to the best of my ability’

Out of Hospital Programme

From:	By doing what:	To:
'I do not know what to do and where to go in an emergency.'		'I could plan ahead and stay in control in emergencies'
'I was not provided with good information about my condition following diagnosis. I no longer feel able to manage without support.'		'I had the information and support I needed in order to remain as independent as possible'
'I was not given the opportunity to input into future care arrangements should my condition worsen.'		'Information about me, including my views and preferences and any agree care plan, was passed on in advance'
'I only have a quick review of my care and treatment once a year. '		'I has regular reviews of my care and treatment, and of my care plan'
'I struggled to keep on top of my medicines regime. Are they all still working?'		'I had regular, comprehensive reviews of my medicines'

PATHWAY SPECIFIC CHANGE

•**Cardiovascular disease*** - focussing on improved prevention and management of stroke, anti-coagulation and community DVT services;

•**Children with Challenging Behaviour** - development of a new multi-agency intensive support team model;

•**Community Nursing** - implementation of a practice level model to ensure that care is coordinated for vulnerable patients groups together with GPs Specialist Nursing – broaden the skills of specialist nurses to be able to manage a greater elements of the pathways for patients with long term conditions;

•**Diabetes*** - implementation of a Type 2 Diabetes primary care training programme and an Integrated Diabetes Care Pathway;

•**End of Life** - improved co-ordination and timeliness of care via a palliative care education programme, increased specialist bereavement counselling and procurement of system wide electronic palliative care system;

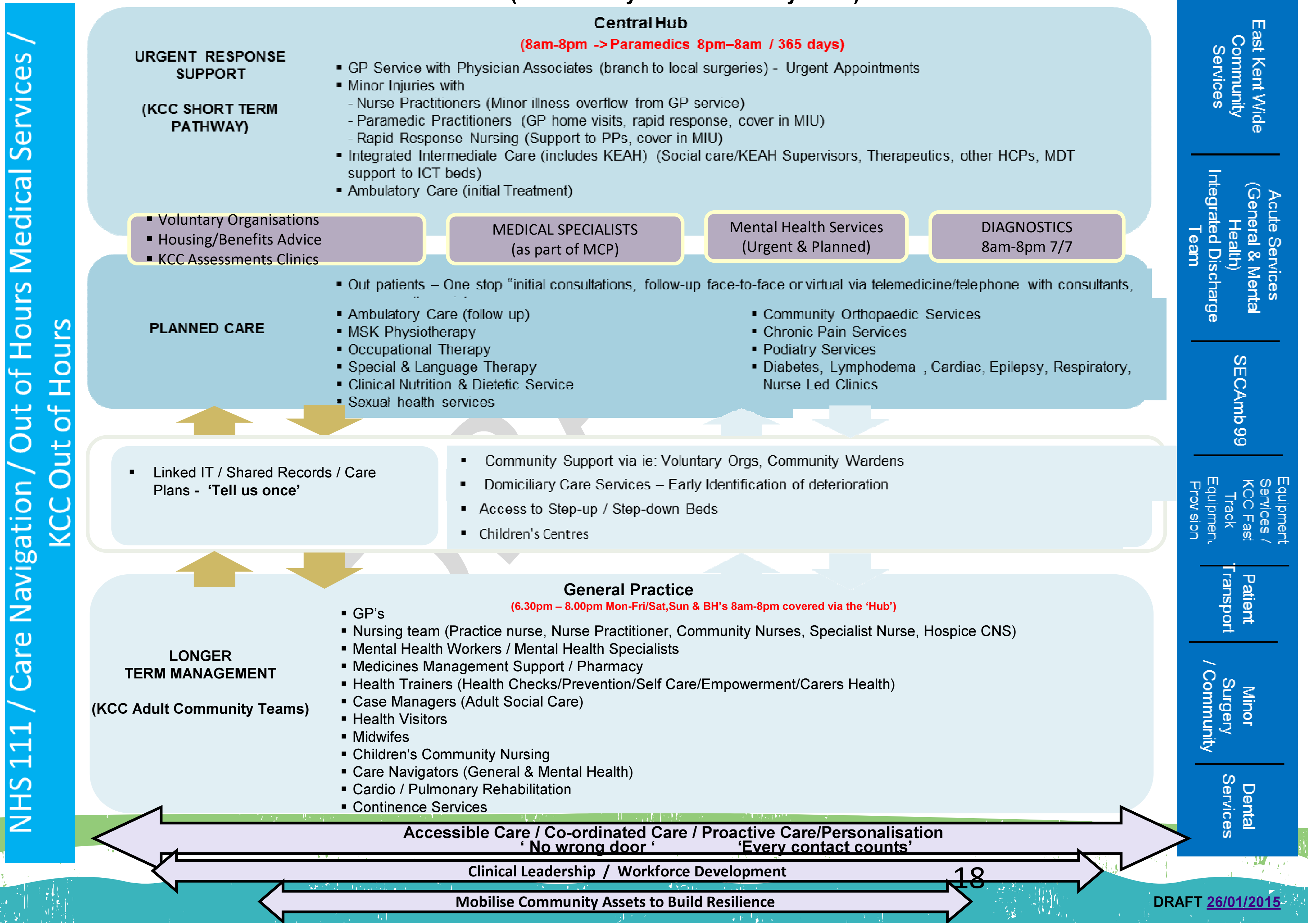
•**Falls*** - improved prevention via a refreshed falls pathway between health, social care and public health;

•**Intermediate Care** - to integrate health and social care elements of intermediate care services to reduce duplication and increase the skill of those delivering intermediate care to build capacity and resilience;

•**Looked After Children** - re-procurement of LAC service;

•**Respiratory Disease* (including Asthma and (COPD)** - implementing integrated pathways / services.

***NHS Right Care: Commissioning for Value Schemes**



Multi-speciality Community Provider (MCP) Model
(Community Hubs / Primary Care)
NHS
South Kent Coast
Clinical Commissioning Group
NHS 111 / Care Navigation / Out of Hours Medical Services /
KCC Out of Hours
Central Hub
(8am-8pm -> Paramedics 8pm–8am / 365 days)
URGENT RESPONSE SUPPORT
(KCC SHORT TERM PATHWAY)
GP Service with Physician Associates (branch to local surgeries) - Urgent Appointments
Minor Injuries with
- Nurse Practitioners (Minor illness overflow from GP service)
- Paramedic Practitioners (GP home visits, rapid response, cover in MIU)
- Rapid Response Nursing (Support to PPs, cover in MIU)
Integrated Intermediate Care (includes KEAH) (Social care/KEAH Supervisors, Therapeutics, other HCPs, MDT support to ICT beds)
Ambulatory Care (initial Treatment)
Voluntary Organisations
Housing/Benefits Advice
KCC Assessments Clinics
MEDICAL SPECIALISTS (as part of MCP)
Mental Health Services (Urgent & Planned)
DIAGNOSTICS 8am-8pm 7/7
PLANNED CARE
Out patients – One stop "initial consultations, follow-up face-to-face or virtual via telemedicine/telephone with consultants,
Ambulatory Care (follow up)
MSK Physiotherapy
Occupational Therapy
Special & Language Therapy
Clinical Nutrition & Dietetic Service
Sexual health services
Community Orthopaedic Services
Chronic Pain Services
Podiatry Services
Diabetes, Lymphodema , Cardiac, Epilepsy, Respiratory, Nurse Led Clinics
Linked IT / Shared Records / Care Plans - 'Tell us once'
Community Support via ie: Voluntary Orgs, Community Wardens
Domiciliary Care Services – Early Identification of deterioration
Access to Step-up / Step-down Beds
Children's Centres
General Practice
(6.30pm – 8.00pm Mon-Fri/Sat,Sun & BH's 8am-8pm covered via the 'Hub')
LONGER TERM MANAGEMENT
(KCC Adult Community Teams)
GP's
Nursing team (Practice nurse, Nurse Practitioner, Community Nurses, Specialist Nurse, Hospice CNS)
Mental Health Workers / Mental Health Specialists
Medicines Management Support / Pharmacy
Health Trainers (Health Checks/Prevention/Self Care/Empowerment/Carers Health)
Case Managers (Adult Social Care)
Health Visitors
Midwifes
Children's Community Nursing
Care Navigators (General & Mental Health)
Cardio / Pulmonary Rehabilitation
Continence Services
East Kent Wide Community Services
Acute Services (General & Mental Health)
Integrated Discharge Team
SECAmb 99
Equipment Services / KCC Fast Track Equipment Provision
Patient Transport
Minor Surgery / Community
Dental Services
Accessible Care / Co-ordinated Care / Proactive Care/Personalisation
' No wrong door '
'Every contact counts'
Clinical Leadership / Workforce Development
Mobilise Community Assets to Build Resilience
DRAFT 26/01/2015

Out of hospital performance targets

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

- Mental Health Programme

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

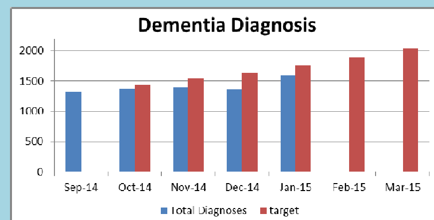
*Achieving Better Access to Mental health Services 2020/Commissioning for Value

Mental Health Performance

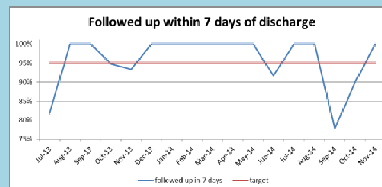
	Target	Performance in 2014/15	Challenges and Improvement Plan

Mental Health

Dementia

	Target	Performance in 2014/15	Challenges and Improvement Plan
% diagnosis rate	66.7%		The CCG aims to improve the identification and care for patients with Dementia. Throughout 2014/15 actions have been taken to increase the number of patients identified as having dementia in all GP practices, including data cleansing and programmes of training and support for practices to sign post and support patients following diagnosis. Practices in SKC have made significant improvement in their rate of diagnosis, with further work planned for 2015/16.

In-patient follow-up

	Target	Performance in 2014/15	Challenges and Improvement Plan
Follow-up within 7 days after discharge from in-patient care	95%		Exception reports for non-compliance are reviewed through contract meetings.

Improved Access to Psychological Therapy (IAPT)

	Target	Performance in 2014/15	Challenges and Improvement Plan
IAPT access proportion	15%	(see table below)	South Kent Coast CCG continues to exceed the target rate for access to psychological therapies. Targets for recovery rates are met for 2014/15. The CCG continues to monitor access and outcomes for psychological therapy on a monthly basis.
IAPT recovery rate	50%		
Treated within 6 weeks of referral	75%	As of January 2015 – average 93% compliance	To be monitored monthly as a new national target in 2015/16
Treated within 18 weeks of referral	95%	As of January 2015 – average 100% compliance	To be monitored monthly as a new national target in 2015/16

	Target	Q1	Q2	Q3
% recovery rate	50%	54%	49%	52%
% of need entered treatment	15%	22%	23%	20%

Early Intervention in Psychosis

	Target	Performance in 2014/15	Challenges and Improvement Plan
Treated within 2 weeks of referral	50%	By April 2016	To be monitored monthly as a new national target in 2015/16

Hospital Programme

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

In Hospital Performance

NHS constitution standards

A&E waits

	Target	Performance in 2014/15	Challenges and Improvement Plan
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	A&E Waiting Times	Nationally reported increases is A&E activity in 2014/15 have resulted in increased demand on acute services. Multi-agency work has been underway to identify key challenges. An action plan has been developed to address system wide and operational improvements. These plans are monitored weekly against achievement of the agreed target recovery trajectory.

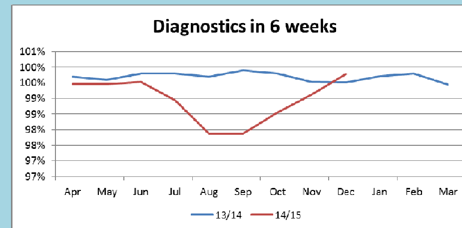
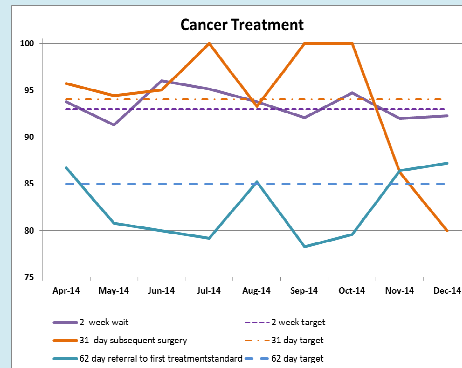
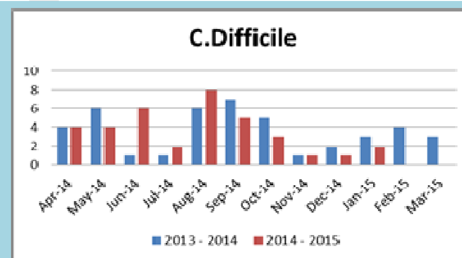
Cat A Ambulance calls

	Target	Performance in 2014/15	Challenges and Improvement Plan
Category A calls resulting in an emergency response arriving within 8 minutes – Red 1	75%	Ambulance Response Times	Achievement of the national targets for ambulance response times has been variable throughout the year. Recruitment of additional paramedics has been initiated in 2014/15, with plan s in 2015/16 to train additional paramedic practitioners. Development of an improved integrated local first responders team is planned for 2015/16.
Category A calls resulting in an emergency response arriving within 8 minutes – Red 2	75%		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%		

Referral To Treatment waiting times for non-urgent consultant-led treatment

	Target	Performance in 2014/15	Challenges and Improvement Plan
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	Referral to treatment in 18 weeks	EKHUFT has failed to achieve the national referral to treatment standard this year. This is due to a growth in referrals into the hospital, particular those relating to Trauma and Orthopaedics. A recovery plan was put in place which included a commitment to clear the backlog. This led to a further reduction in performance as 18+ week waiters were moved to treatment. The recovery plan was initially expected to ensure compliance by April 2015, but difficulties in reducing the backlog mean that compliance is now unlikely until Q2 2015/16. A single point of access for orthopaedic referrals has been introduced in 2015, showing a significant reduction in referrals from SKC.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%		

In Hospital Performance cont.

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

Our approach to improving Health Inequalities in 2015/16

South Kent Coast Health Inequalities Improvement Approach

Health Inequalities Strategy

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

Health Inequalities Work Plan

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

Our approach to Governance and Assurance in 2015/16

- The Governing Body Assurance Framework identifies the CCG's key strategic risks. These include delivery of our strategic objectives, statutory targets and statutory obligations. The Governing Body reviews the Assurance Framework regularly to ensure that the risks are being managed and effectively mitigated.
- All of the GP practices in SKC are members of the CCG. They meet throughout the year, four times informally and twice formally and in public. The GP practices have been engaged in developing the CCG Plan. The Governing Body regularly reviews the delivery of the CCG Plan, hearing from the Lay Member about public and patient engagement, considers the performance of its key providers, and reviews the financial position of the CCG. The Clinical Cabinet provides clinical leadership for the delivery of the CCG Plan and strategic clinical oversight.
- Monitoring the performance of the providers is a key responsibility of the Governing Body. A detailed review of quality and performance takes place at the Quality and Performance Committee, which focuses on reviewing the delivery of quality and constitutional targets, including A&E attendance, cancer targets, referral to treatment times and dementia. It identifies issues for escalation to the contract performance meetings and monitors local recovery plans to address these risks. Performance is also monitored weekly by the Executive team which informs the accountability discussions with providers at the contract delivery meetings.
- The Governance and Risk Committee has responsibility for audit and for providing assurance to the Governing Body that the systems and processes which the CCG has in place are working well. The Governance and Risk Committee undertakes "deep dives" into issues of clinical and corporate significance e.g. prescribing. They also review the adequacy of the assurance arrangements which the CCG has in place.
- The CCG cannot deliver its ambitions on its own. We work in partnership, particularly with Dover and Shepway District Councils and all members of our local and county Health and Wellbeing Boards.

DRAFT

Our governance structure that will assure delivery is illustrated below.

SKC Governance Structure

31 practices mandate to Governing Body

Health reference group supported by Practice and locality PPGs

Locality Groups	MEMBERSHIP COUNCIL	CCG PPG & Health Network	GOVERNING BODY
Dover/Deal Shepway	Meeting 6 x pa Informally x 4 With all Practice Leads, GB GP's and other nominated attendees Formally x 2 as full membership Council with all GP's invited PLT, PM and PN For a tie into joint localities work & clinical strategy work groups		Elected members: • Chair: GP Clinical Lead • 5 GP/Clinical leads Appointed members: • Chief Officer (AO) • Chief Finance Officer Independent members: • Lay - governance • Lay – Patient & Public Involvement • Clinical – secondary care doctor • Clinical – registered nurse (Chief Nursing Officer) *(CO, CFO and CNO – shared with Thanet CCG)* No-member observers Eg. PPG ....
GP PLT, practice manager	CCG staff team led by Chief Operating Officer supported by KMCS		
GB roles for local GP + locality team			

NHSCB and other statutory bodies

Federation role, strategy, accountability

Federation of East Kent CCGs
- Clinical forum
- Federation forum
- Whole System Board

GOVERNING BODY COMMITTEES
Governance and Risk
Remuneration & Nominations
Clinical Cabinet
Quality and Safety
Performance and Delivery

SKC Health & Wellbeing Board and system engagement

Better Care Fund Plan 2015/16

Vision

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

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

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

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

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

Changes to service configuration

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

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

Patient and service user outcomes

By working in new and innovative ways we aim to achieve the following:

- Focus on prevention and targeted interventions to support peoples overall health and well-being;
- Ensure services respond rapidly and more effectively to patient’s needs, especially at times of crisis;
- Support carers and empower individuals to do more for themselves;
- Improve the overall patient experience of the delivery of care.

Aims and objectives of an integrated system

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

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

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

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

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

Measuring improved outcomes

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

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

Integrated Teams and Reablement

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

SCHEME REQUIREMENTS:

Integrated Intermediate Care Pathway & flexible use of community based beds

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

Enhanced Rapid Response – supporting acute discharge/preventing readmission

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

Integrated rehabilitation & Non Weight Bearing Pathway

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

Enhance Practice Level Teams and Care Coordination

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

SCHEME REQUIREMENTS:

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

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

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

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

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

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

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

Specialists to integrate into community based generalist roles

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

Enhance Primary Care

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

SCHEME REQUIREMENTS:

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

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

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

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

Enhance support to Care Homes

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

SCHEME REQUIREMENTS:

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

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

Integrated Health and Social Housing approaches

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

SCHEME REQUIREMENTS:

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

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

Falls prevention

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

SCHEME REQUIREMENTS:

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

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

Local integrated falls prevention pathways

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

Success factors and timeframes for delivery

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

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

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

Alignment with local JSNA and local commissioning plans

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

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

Implications on the acute sector

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

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

Governance

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

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

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

Protecting Social Services

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

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

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

7 day services to support discharge

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

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

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

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

Data Sharing

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

NHS

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

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

Social Care

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

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

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

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

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

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