NHS Swale 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 been an integral part of in terms of design and content.

The CCG Vision is to commission health services that meet the needs of the Swale population, provide value for money, address health inequalities, and improve health outcomes, to enable the population of Swale to lead healthier and more independent lives.

This vision cannot be delivered in isolation by the CCG, and 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 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.

The Executive Programme Board forms part of this joint governance structure and through this we have elicited a whole system agreement to reduce emergency admissions by providing such integrated care that wraps around the patient and supports GPs to proactively identify and manage vulnerable patients. Thus, enabling them to remain as independent as possible.

The Plan on the Page diagram (2014-2019) (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 deliver 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 Swale whereby primary, community, mental health and urgent care (including SECAMb, NHS111 and Out of Hours) work seamlessly together with the local authority, Borough Council, third sector and voluntary providers to deliver the health and well-being priorities for local people and their communities including sub-acute care delivered by specialists employed by the community or through an outreached capacity by a number of acute providers. 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.

The CCG and local GPs are actively pursuing true integrated primary care (through our Integrated Primary Care Teams – IPCTs) and want to expand on this model by exploring further alliances with community and social care providers and particularly South East Coast Ambulance Service to provide extended and integrated primary care and sub-acute care services across Sittingbourne and the Isle of Sheppey.

Through doing the above, we want to ensure that health and healthy living is a priority in the redesign of urgent care, community and primary care services, particularly using our community hospitals as central hubs. We have a unique opportunity, with Kent County Council (KCC), to contribute to the design of good living space within the proposed developments laid down within the KCC estates strategy. In addition, there is a unique opportunity within Sheppey hospital to design a health and social care hub with the facility for full and enhanced diagnostics, delivery of ambulatory and sub-acute care and a range of planned and urgent extended primary care services, with health and wellbeing at the fore and new clinical delivery designed from scratch. This sits well with the changes in our demographics and focus on prevention and the reduction of health inequalities. 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. We have applied to become a **Vanguard Pilot** as we believe this support us in delivering at pace and extending and enhancing the strong collaborative partnership that already exists across this community.

NHS Swale has 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 Fund 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 Swale 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 more 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, in particular, within community estates and integrated care within peoples' homes. By following through the recommendations, the Kings Fund believes that the system and acute hospital could absorb and manage the expanding elderly population

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

- Enhance the Integrated Discharge Team model and have a working and fully implemented network of integrated primary care teams in place across Swale. 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;
- 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.

NHS Swale 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 (NHS Dartford, Gravesham & Swanley CCG and NHS Medway 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 is already forging strong partnerships with the Royal Colleges and NHS Employers. Outcomes so far have been;

- An increase in the number of training practices within Swale: in the last 12 months we have moved from having no training practices in terms of medical GP trainees, to having four larger practices across Sheppey and Sittingbourne now registered and validated to take on trainees.
- The ERIH has also resulted in the 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. Four practices are working with local universities in conducting research relating to the commissioned alcohol and benzodiazepine reduction schemes within Swale.

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

NHS Swale CCG has strong relationships with public health 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 resource has significantly contributed to much richer, standardised data and the evaluation of schemes and programmes. The post acts as an effective bridge between general practice and the local authority in terms of design 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 CCG's 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 Medway FT Hospital A&E - £119k
- ASD investment - £35k
- Armed Forces contract investment related to Veteran mental health - £5k.
- Mental Health Placements – expected increase – £150k
- ADHD Satellite Clinic - £174k

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 £3.2m 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
- Better Care Fund
- Patient Transport tender (transforming patient services)
- Investment in Mental Health

The CCG has also received 1.4% GDP growth of £1.7m, winter resilience funding of £0.7m and the Better Care Fund transfer of £2.1m. The CCG has a non-recurrent return of surplus of £1.4m. The CCG proposes to use Winter Resilience to fund the Integrated Discharge Team.

Allocation 15-16	£000
Recurrent Baseline 14-15	123,252
1.4% Growth	1,726
Post M7 Allocation (Spec Comm)	300
Post M7 Allocation (HIV Drugs)	209
Winter Resilience	670
Distance from Target	3,229
Better Care Fund	2,067
Total Programme Allocation	**131,453**
Running Costs	2,374
Total Recurrent Allocation	**133,827**
Return of Surplus	1,426
Return of CHC Risk Pool	294
Total Allocation	**135,547**

QIPP 2015/16

The largest programmes in terms of financial gain are:

Swale QIPP by Programme 2015/16	Saving £000	Investment £000	Planned Net Saving £000
Urgent Care	(954.2)	172.2	(782.0)
GP prescribing	(587.0)	116.0	(471.0)
Planned Care	(503.1)	171.8	(331.3)
Mental Health	(451.0)	196.5	(254.5)
LTC	(222.6)	0.0	(222.6)
Primary Care/Health Inequalities	(130.9)	0.0	(130.9)
Continuing Care	(125.0)	0.0	(125.0)
Other	(101.6)	119.0	17.4
	(3,075.4)	**775.4**	**(2,300.0)**

The CCG is continuing with its integrated discharge team and integrated primary care teams. These are expected to prevent A&E admission and non-elective admission as patients are managed within the community. The Better Care Fund will also focus on health services working with social care. *(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 finalised, and providers need to confirm which they would prefer to use by the 4th March, currently 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 31st March 2015.

3. Routine Seasonal Resilience is now included in recurrent allocations, but that for Ambulance Services is not and is held centrally. The cost of this is shown as a mitigated risk in the planning forms.

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 the Swale Five year Commissioning Strategy). This has 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,
- 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:

- A reduction in the number of patients within our community hospitals being placed there whilst awaiting permanent care; a reduction from 66% of patients placed into community services with no rehabilitative need, to less than 30% awaiting permanent care following rehabilitation;
- Since Jan 2014, no patient has been admitted into long term care from the acute trust and 95% of patients have been successfully discharged to their original place of residence;
- A reduction in the number of duplicate care plans and services through the introduction of integrated teams;
- A corresponding increase in spend for re-ablement;
- 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;
- A health system where both commissioners and the majority of its 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 Swale these providers are South East Coast Ambulance Service (SECamb) and Kent Community Healthcare Trust (KCHT). The CCG also works closely with Medway CCG in relation to quality and safety at Medway Foundation Trust (MFT) and with Dartford Gravesham & Swanley (DG&S) CCG in relation to Kent and Medway Partnership Trust (KMPT). Across these providers the main focus areas include:

- **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.
- **KCHT** - The CCG is working to gain greater assurance around Looked After Children (LAC) arrangements with the trust.
- **MFT** - There are ongoing quality and safety concerns across the organisation. The trust is not meeting constitutional targets particularly in relation to Mixed sex accommodation and HCAI.
- **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.

Swale CCG has arrangements in place with DG&S CCG and Medway CCG to collaborate on the functions of the Quality and Safety team which includes safeguarding children and adults. Swale CCG also 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 Swale CCG has failed to meet the following NHS Constitution targets on a year to date basis.

- Referral to treatment (admitted patients within 18 weeks – YTD (Dec) performance 88.17% and Q3 performance 83.5%
- Emergency access – A&E 4 hour waits – YTD (Dec) performance 83.74% and Q3 81.43%
- Cancer – two week wait from Urgent referral – YTD (Dec) performance 92.79% achieved at Q3 at 95.35%
- Cancer – 62 day urgent referral to first treatment – YTD (Dec) performance 77.70% and Q3 81.03%
- Ambulance response (Trust level) R2 performance YTD (Jan) performance is 74.3%

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.

Swale, 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.

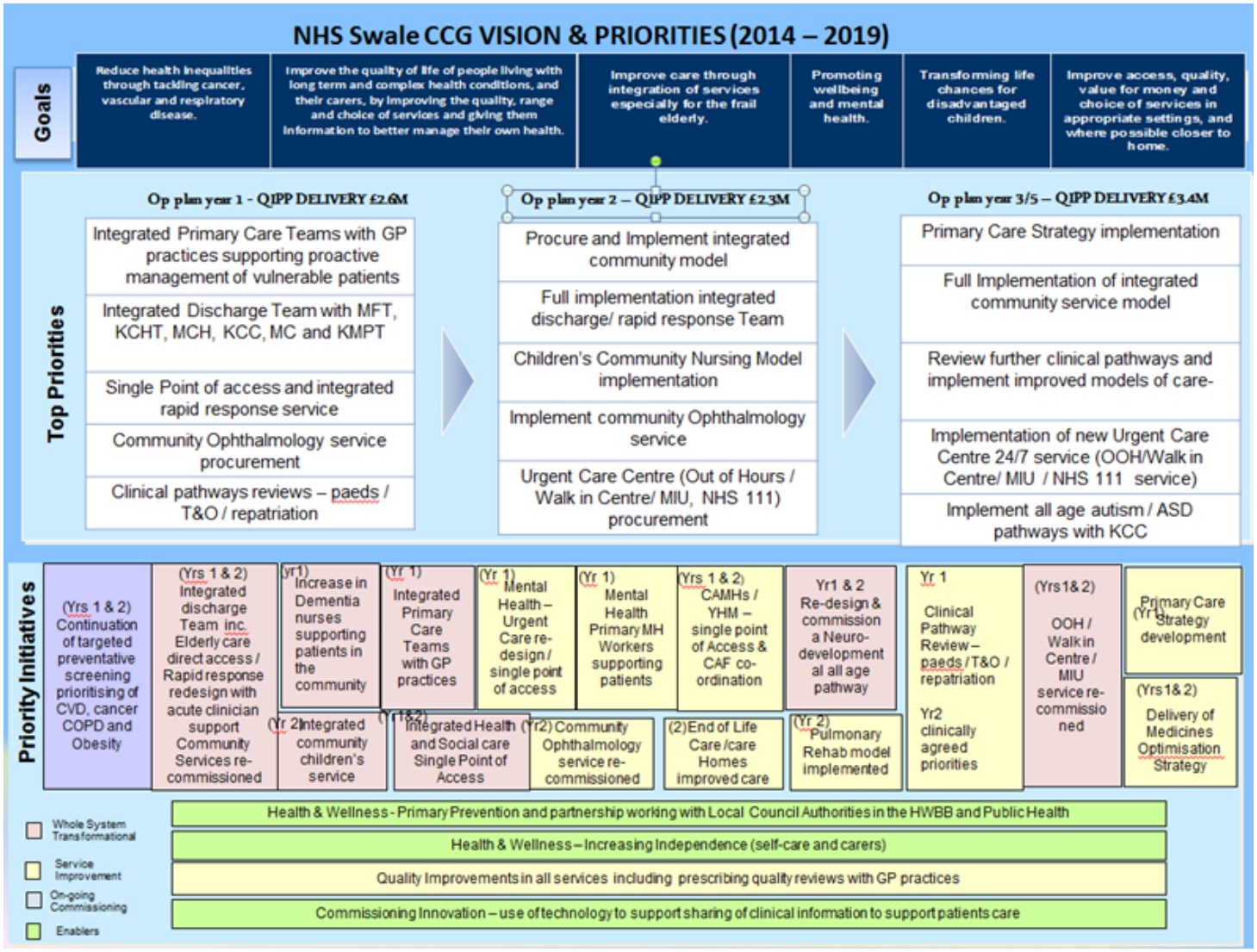
The Kent HWBB have agreed with all Kent based CCGs that the original ambition of 3.5% reduction in NEL admissions is not achievable due to the current significant demand on the acute system and Swale CCG has agreed a 0.8% NEL admission reduction target as part of the BCF (*Reference: Swale Strategic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

The operating plan describes our CCG Governance processes.

Appendix A – NHS Swale CCG Plan on a Page 2014 -19



Appendix B – Details of the QIPP key projects.

QIPP Programme Area	Point of Delivery impacted	15/16 Planned Activity Changes	Total planned 15/16 finance reduction £000	Total Per Point of Delivery	Total per QIPP Area	Project Name
Urgent Care	Accident and Emergency	-129	-£13			Falls Prevention
Urgent Care	Accident and Emergency	-300	-£16			North Kent Review of Urgent and Emergency Services
Urgent Care	Accident and Emergency	-7	-£1			Staying Put
Urgent Care	Accident and Emergency	-156				Dementia crisis and carers short breaks
				-£31		
Urgent Care	Long Stay Emergency Admission	-43	-£108			Befriending Home from Hospital Service (Age UK)
Urgent Care	Long Stay Emergency Admission	-52	-£134			Admission avoidance and facilitated discharge schemes
Urgent Care	Long Stay Emergency Admission	-120				Dementia crisis and carers short breaks
Urgent Care	Long Stay Emergency Admission	-60	-£150			Impact of primary care schemes (ie: iPCTs, MDTs)
Urgent Care	Long Stay Emergency Admission	-15	-£33			Improved end of life care
Urgent Care	Long Stay Emergency Admission	-7	-£35			Staying Put
Urgent Care	Long Stay Emergency Admission	-45	-£103			Support to Care Homes (Nursing and Residential)
Urgent Care	Long Stay Emergency Admission	-24	-£64			Teletechnology in care homes
Urgent Care	Long Stay Emergency Admission	-50	-£117			The Frailty Pathway
				-£744		
Urgent Care	Long Stay Emergency Excess bed days	-396	-£82			Dementia crisis and carers short breaks
				-£82		
Urgent Care	See&Convey	-129	-£22			Falls Prevention
				-£22		
Urgent Care	See&Treat	129	£14			Falls Prevention
				£14		
Urgent Care	Short Stay Emergency Admission	-27	-£61			Admission avoidance and facilitated discharge schemes
Urgent Care	Short Stay Emergency Admission	-20	-£14			Support to Care Homes (Nursing and Residential)
				-£75		
Urgent Care	Other		£9			Befriending Home from Hospital Service (Age UK)
Urgent Care	Other		£60			Improved end of life care
Urgent Care	Other		£85			Staying Put
Urgent Care	Other		£2			Support to Care Homes (Nursing and Residential)
				£155		
Total Urgent Care					**-£783**	
GP prescribing	GP practice		-£11			GP IT support system
GP prescribing	GP practice		-£133			Practice Work
GP prescribing	GP practice		-£367			Prescribing incentive Scheme
GP prescribing	GP practice		£6			Waste reduction project
				-£505		
GP prescribing	Pharmacies		£34			Sleep clinic to support children at MFT
				£34		
Total Prescribing					**-£471**	

QIPP Programme Area	Point of Delivery impacted	15/16 Planned Activity Changes	Total planned 15/16 finance reduction £000	Total Per Point of Delivery	Total per QIPP Area	Project Name
Planned Care	Attendances - community	594	£24			Community Ophthalmology Service
				£24		
Planned Care	Direct Access Pathology		-£300			Pathology Review
				-£300		
Planned Care	Outpatient Bundle	1,810	£172			Level 3 Dermatology Service
				£172		
Planned Care	Outpatient First Single Professional	-680	-£80			Level 3 Dermatology Service
Planned Care	Outpatient First Single Professional	-136	-£16			Community Ophthalmology Service
Planned Care	Outpatient First Single Professional	1,508				MTW OP Project
				-£96		
Planned Care	Outpatient Follow-up Outpatient Procedure	-333	-£43			Level 3 Dermatology Service
				-£43		
Planned Care	Outpatient Follow-up Single Professional	-797	-£57			Level 3 Dermatology Service
Planned Care	Outpatient Follow-up Single Professional		-£30			Community Ophthalmology Service
				-£87		
Total Planned Care					**-£330**	
Mental Health	Accident and Emergency	-100	-£9			Peer Support Group
				-£9		
Mental Health	Block - community	-2	-£22			Peer Support Group
Mental Health	Block - community		£15			Peer Support Group
Mental Health	Block - community	-28	-£65			Primary Care Mental Health Specialists
				-£72		
Mental Health	Placements		-£125			MH Placement Reduction
				-£125		
Mental Health	Short Stay Emergency Admission	-180	-£111			Liaison Psychiatry
				-£111		
Mental Health		0	£13			Primary Care Mental Health Specialists
Mental Health		0	£50			Primary Care Mental Health Specialists
				£63		
Total Mental Health					**-£255**	
Primary Care/Health Inequalities	Long Stay Emergency Admission	-42	-£95			Health Inequalities - projects
				-£95		
Primary Care/Health Inequalities	Short Stay Emergency Admission	-21	-£15			Health Inequalities - projects
				-£15		
Primary Care/Health Inequalities			-£20			GP Care Hub/Extended Hours - Placeholder
				-£20		
Total Primary Care / Health Inequalities					**-£130**	
Continuing Care	Placements		-£125			CHC Placement Reduction
				-£125		
Total Continuing Care					**-£125**	
Integrated	Block - community	-100	-£2			Primary care based memory assessment services
				-£2		
Total Integrated					**-£2**	
Other			-£204			Various
				-£203		
Total Integrated					**-£203**	
Total QIPP					**-£2,300**	

Appendix C – NHS Swale CCG Constitutional Performance and actions

High Risk Area : A&E 4 Hour wait	
Current position	The standard has been consistently failed throughout 2014/15 due to the performance at Medway NHS Foundation Trust (MFT).
Diagnosis	As previously reported there are long standing cultural issues of poor clinical leadership and engagement and a lack of performance management at the hospital; poor management of flow through the hospital with no differentiation between short and long stay patients; and a lack of effective process for both complex and non-complex discharge. MFT remains in special measures and rated as 'inadequate' by the CQC.
Action	At a national/regional level there has been oversight through Monitor as the regulator of the Trust. NHS England has also held a number of Risk Summits with MFT, regulators, commissioners and other partners. At a local level whole system challenge and oversight is in place through the Medway and Swale Executive programme Board supported by a number of plans. A refocused whole system plan was agreed following a Star Chamber meeting with NHSE and Monitor; this included a revised trajectory to achieve 95% by March 2015. The Trust now has a single 18 month plan which incorporates all previous action plans and requirements, running through to April 2016. . The significant increase in admissions in 2014/15 (47% to January), specifically December and January, has had an impact on the recovery plan. Some of this increase would have been increased acuity but the continued internal operational issues will also be a large factor. There was not the same increase in overall attendances – with only an 8.2% increase April to January. As part of the ORCP the Oak Group were commissioned to complete an Audit of admissions and beds/stays (Jan 2015). This audit highlighted that 26% of admissions and 54% of continuing stay days were non-qualified and could have been provided at an alternative level of care. *It should however be highlighted that his was a point in time audit and there should be no assumption made that 26% of admissions could be instantly avoided or all continuing care stays could be reduced.* Immediate action was agreed at the Executive Programme Board (EPB /SRG) to commission the Oak Group STREAM model within ED for 4 months (from March 2015). This is focused on understanding on a 'live' basis the non-qualified admissions and also understanding connectivity to community health and social care pathways, specifically response times and service needs in terms of avoiding admissions and supporting people at home/other community setting. This will provide the system with real time intelligence and feed into the wider executive discussions established to review themes in order to identify and agree changes that can be made.
Trajectory for 15/16	The Trust is working to achieve 95% in March with a number of plans coming on line 2 March – including STREAM, Geriatrician of the day and changes to wards with two to focus on lower acuity/Medically fit for discharge to support efficiency of Trust and IDT processes. The CCG will monitor progress during March (daily oversight on performance) but at this time is expecting the 95% standard to be achieved consistently during 2015/16, despite the current limited performance improvement. This will be reviewed during March and if required improvement to headline performance is not seen then a revised trajectory and recovery plan will be agreed for 15/16.
Investment	No additional investment is built into the plan , all activity paid through PbR.

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. MFT has had one of the highest '"lost hours" due to handover delays in 2014/15.
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 MFT are starting to positively impact as in January and February there has been an improvement in all areas which has contributed to a 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 MFT contract.
Investment	No specific investment. Contract negotiations focusing on totality of activity.

High Risk Area: 18 week referral to treatment (RTT)for admitted pathways	
Current position	Due to the agreed suspension of RTT reporting at Medway NHS Foundation Trust the reported figures at CCG level from December 2014 exclude all activity treated at MFT and is therefore not a true reflection of the CCGs actual performance. On average Medway NHS Foundation Trust would generally contribute two thirds of the CCG overall activity.
Diagnosis	Agreement was reached with Monitor that RTT reporting would be suspended until 2015/16 to allow the Trust to complete a data quality review which would also support the move to a new PAS system in February 2015. (Note – PAS implementation successful)
Action	Whilst reporting is suspended the CCG has maintained oversight of RTT activity. As part of the additional RTT funding designed to reduce the number of patients who have waited more than 18 weeks and have not yet been treated (referred to as 'backlog'), it had been anticipated that MFT would start to treat a proportion of the backlog activity however due to the high demand on non-elective services (ref A&E narrative above) in December and January the Trust suspended the elective activity which has resulted in a further significant increase in the backlog. To date limited off site activity has occurred although the Trust are planning to offer off site choice to patients for the Independent Sector during March and into 2015/16. Any additional activity in March will not be sufficient to reduce the backlog to a sustainable position by 1 April 2015 but we expect continued off-siting to deliver a sustainable position by the end of Q2.
Trajectory for 15/16	The CCG is currently assessing the position with MFT and is awaiting the most up to date backlog information (following an agreed reporting suspension over PAS go live) in order to model the activity and RTT performance. Given the significance of the backlog the CCG is working to agree a recovery plan, aligned to a clear reporting and performance management framework, with MFT for the first 6 months of 2014/15.
Investment	Additional Investment will be required and contract plans will be adapted to reflect the required reduction in the backlog.

Cancer Access Targets • **Cancer - two week wait from urgent referral for breast symptoms** • **Cancer – 62 day wait from referral to first treatment** • **Cancer – 62 day wait from referral from screening to first treatment.**	
Current position	• Cancer two week wait from urgent referral – performance for the year to date (to dec) is 92.79% and 95.35% for quarter 3 • Cancer - two week wait for breast symptom referral - performance for the year to date (to dec) is 93.28% and 88.49% for quarter 3. • Cancer - 62 day urgent referral to first treatment - performance for the year to date is 77.70% and for quarter 3 it is 81.03%
Diagnosis	Data Quality, process and recording issues identified. (See below)
Action	Assurance has been sought from MFT for all cancer targets but specifically two week wait (all and breast symptoms) and 62 day wait pathways. The response to the contract query regarding two week waits highlighted that the breach reasons had been incorrectly recorded. There are however acknowledged issues regarding data quality following a review by PricewaterhouseCoopers (PwC) and the Trust are not therefore able to give complete assurance regarding delivery of all standards. PwC are now undertaking a further piece of work to review all current recording and reporting processes and the CCG have requested the Terms of Reference for the review and regular updates will be provided to the CCG. Breaches of the operational standards for Cancer Waiting Times will continue to be raised in the Provider performance letter and the contract query is on hold until the outcomes of the PwC review. The CCG is also requesting a review of patient notes
Trajectory for 15/16	To be confirmed following PwC review but early information would suggest recovery plan for Q1 (minimum) will be required. Being discusses at contract performance meeting on 4th March 2015.
Investment	No specific investment requirements.

Appendix D – Programme Summaries

Programme Area: Urgent Care

Objective:

- To review urgent and emergency care services across North Kent to shape and structure future model of care which provides highly responsive, effective and personalised services.
- To achieve a reduction in the number of A&E attendances and non-elective short and long stay admissions by supporting people to manage their condition in the community
- To reduce the number of ambulance conveyances by appropriate use of alternative pathways and services in the community.

Key Drivers for Change:

- Growth in the elderly population
- The Oaks Group capacity work supporting initiatives for patients to be looked after in the community with appropriate support from health and social care services
- The need to provide support to enable people to die at home should they prefer to
- NHS Outcomes Framework and Keogh Mortality Review 2013 – The Review identified areas with scope for improvement within the Trust which the urgent care programme supports
- The NHS Five Year Forward View – supporting the redesign of urgent and emergency care services to integrate between A&E departments, GP out of hours services, urgent care centres, NHS 111 and ambulance services

What did our providers and GPs tell us?

- Issues relating to access of acute services, effective discharge of patients, lack of nursing home beds, inappropriate attendances at A&E, acuity of patients presenting at A&E, poor quality discharge information
- Impact of urgent care pressures on the provision of elective care at the Acute Trust

What did our patients and local population tell us?

- Patients want clarity of services with easy and timely access
- They want alternatives to hospital and want to remain living independently within their homes as far as possible with the appropriate support
- They want to be able to make informed choices and be supported to plan their end of life care

Key Projects and milestones
(Continuation of projects for 14/15

- **Support to care homes:** Dedicated nursing and residential care home community matrons providing hands on care and out of hours advice and guidance. Working in partnership with Kent County Council, a review of nursing homes will be undertaken to understand the current provision and future need specifically in Sheppey.
- **Improved end of life care:** Through the identification of patients nearing the end of life, supporting them with advanced care planning. Agreed advanced care plans will be in place and the My Wishes End of Life Register will be available to record patients care plans.
- **Handypersons scheme**: Continuing the partnership with Swale Borough Council to support Swale residents (over the age of 65) to live safely and independently within their homes.
- **Reduction in A&E attendances:** A range of projects including reviewing the SECAmb pathways and minor injury units, ensuring optimum use in Swale. Rolling out localised 'Chose Well' media campaigns to raise awareness of alternative services to A&E supported by the Health Help Now website and mobile app.
- **Integrated Health and Social Care Admissions Avoidance and Discharge Teams/Integrated Primary Care Teams:** Continuation of the Team to support proactive discharge planning for complex patients and admission avoidance. Working to the 'home is best' principle, supporting patients at home with appropriate enablement packages

(New projects for 15/16)

- **North Kent Urgent and Emergency Care Review**: To provide access to the highest quality urgency and emergency care within an integrated approach for the population of Swale
- **Partnership working with voluntary organisations**: To provide support to people within the community, reducing unplanned A&E attendances and admissions. Providing support to elderly patients on discharge from hospital
- **Falls prevention**: Working with social care partners, providers and MCCG to ensure a standard evidence based approach to identifying patients at risk of a fall and ensuring appropriate prevention services are in place

Programme Area: Urgent Care

Risks and mitigating actions:

- Large scale organisations change and patient behaviour change required to address impact of pressure from surges in non-elective activity. Significant focus and work in progress monitored through the Executive Programme Board
- Project Board Steering Group to oversee progress and delivery of North Kent Urgent and Emergency Care Review and Redesign
- Provider engagement in commissioning intentions will be key to their successful delivery which will be closely and regularly monitored
- Projects funded through 2014/14 resilience funds will be monitored and reported on a monthly basis to the Executive Programme Board through a PMO approach

Workforce implications:

- Implementation of the Integrated Primary care Teams and the expansion of the Integrated Discharge Team will be integral to the delivery of the reductions in post NEL attendances and admissions.
- Increased support from voluntary organisation s
- The commissioning intentions for urgent care aim to shift delivery of care, where possible, from the acute to the community. This may require flexibility by providers with their skill mix

Resource implications:

2015/16
Planned net savings: £863,584
Schemes within the Urgent Care Programme will contribute to savings in A&E attendances and short and long stay non elective admissions
Non elective long and short stay admissions: -£844,984
A&E Attendances: -£18,600

KPIs (linked to national KPIs):

- Achievement of all national indicators in relation to urgent care, including the 4hour A&E access target and ambulance response times
- Delivery of a reduction in non-elective admissions
- Delivery of a reduction in emergency admissions for acute conditions that should not usually require hospital admission
- Delivery of a reduction in the number of people admitted to hospital at the end of life and an increase in the number of people supported to die in their preferred place of care
- Increase in the number of people supported to live safely and independently within their home

Programme Area: Planned Care and Cancer

Objective:

- Improve access, quality, value for money and choice of services in appropriate settings and, where possible, closer to home
- Reduce Health Inequalities through tackling Cancer, Vascular and Respiratory disease

Key Drivers for Change:

- These pathways were identified in a number of GP forums as having a need for review, optimisation and simplification. Data shows an increase in demand for many of these services and a predicted rise in elderly patients is expected to increase demand.
- Cancer is one of three key causes or mortality for Swale
- In addition providers are reporting pressures on certain specialities (Dermatology, Ophthalmology, Neurology and Gastroenterology) due to either increasing demand or in some cases lack of capacity and availability of key specialists nationally. It is therefore imperative that we use our resources to commission the most efficient and effective service for the patients of Swale and make best use of the available expertise.

What did our providers and GPs tell us?

- There is complexity, duplication and workforce pressures in secondary care in dermatology and ophthalmology where there are community services that could be better integrated across the whole system. There are newly emerging pressures in Gastroenterology and Neurology impacting on service delivery.
- There is scope to introduce or improve provision of services in a primary or community setting to reduce pressure on secondary care and improve value for money e.g. Ophthalmology, Dermatology, ENT and Gynaecology, but this needs to avoid adding to the complexity and duplication.
- While there is a variation in the use of Choose and Book the general ethos of an electronic booking service that delivers efficiencies is welcomed by both GPs and Providers – therefore the delivery of a service that is easy to use is key
- Access to diagnostics is a continuing issue – whether GP direct access, timely introduction of new evidence based pathology (e.g. Faecal calprotectin),or within the hospital setting (e.g. on 2WW pathways).

What did our patients and local population tell us?

- Stakeholder/patient engagement events have told us that patients want, where possible, locally accessible services.
- They want complexity and duplication removed from the system therefore avoiding need for multiple appointments with multiple providers. They also want to ensure that services such as outpatient clinics provided in community setting are equitable with those provided in the acute hospital setting.
- They have also told us they would like to be involved in service redesign groups to give the patient voice.
- They have told us that they like Choose and Book when they have been offered the chance to use it.

Key projects and milestones:

- Integrated Community Dermatology – working with North and West Kent CCGs to procure a level 3 service providing a sustainable and value for money service offering appropriate and safe care in the right setting (procurement and mobilisation in 2015)
- Review of whole systems ophthalmology service – Working with North Kent CCGs procurement of new service in 2015 based on review findings. Continue in year pathway and workforce development building on PEARS and IOP Repeat Measures pilots.
- Medway Outpatient Improvement Programme – work on this has been wound back due to other priorities at MFT. Work has shifted to exploring options at other local Trusts for planned shift of OP work – evaluation of pilots in Cardiology, CoE and Respiratory at MTW.
- Cancer - Recruit and establish MacMillan GP Facilitator role to provide clinical leadership to Swale Cancer work.
- Cancer Improving access to early diagnostics – implementation of national directives for direct access to flexible sigmoidoscopy and brain MRI. Monitor impact.
- Cancer – having worked with Strategic Clinical Network to review pathways in Lung, Breast and Colorectal Cancer implement recommendations appropriately.
- Anti-coagulation care transfer – continuation of project to transfer care to community setting from the acute. Plan to procure a value for money service offering appropriate and safe care in the right setting (procurement in 2015)
- Continue review of ENT in particular community audiology and scoping of community ENT clinics.
- Scoping work to review Neurology and Gastroenterology services (2015)
- Pathology – review of pricing with MFT and scope of service including introduction of new and decommissioning of obsolete tests.
- Re-Procurement of AQPs in Independent Sector Electives and Diagnostics and Physiotherapy – subject to review.

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.
- Transactional financial savings and best practice targets are dependant on contract negotiations and will need to be reviewed once negotiations finalised.

Workforce implications:

- Key within this programme is the acknowledgment that delivery of changes within this area is underpinned by ongoing education for clinicians – this will be provided via regular updates through CCG bulletins, website and Protected Learning Time events. We have successfully added a Practice Nurse education programme to PLTs through 2014 and will continue this. We have additionally organised a GP Hot Topics event in Cancer with SCN and will explore these opportunities further to develop our primary care workforce.
- In addition, key projects around ophthalmology and dermatology have been developed to address capacity issues within current services.

Resource implications:

2014/15:

- Planned net savings £375,464
- Transactional pathology pricing review -£300,000
- Transfer of activity to primary (including optometry) and community care setting (2404)
- DGH New outpatients reduction (-816)
- DGH Follow up outpatients reduction (-1255)
- DGH Outpatient procedures (-333)

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:

Key projects and milestones:
IAPT – Improving Access to Talking Therapies. 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
Continuation of the Primary Care Community Link Worker project – jointly commissioned 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 – this continues in 2015-16
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 assessment 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 required numbers of patients to be referred to Primary Care Mental Health Specialists will not be met. We are working with KMPT to ensure appropriate patients are discharged. Steering Group in place to monitor. Results from the pilot so far indicate that this is not a concern.
- Risk that Primary Care Mental Health Specialists capacity will not meet demand. Sharing resource across the CCGs will alleviate this whilst also ensuring numbers to be discharged are realistic based on capacity.
- Risk that identified population need to enter talking therapies will not be met. Continuous engagement with GPs, working with providers. Advertisement on live it well website. Activity monitored through the local contracting and performance groups.
- GP practices have limited capacity and therefore primary and community services will be put in place are able to manage demand and support GP practices without placing unnecessary pressure on practices.

Workforce implications:

- Early Intervention posts to be recruited, and workers for the Personality Disorder peer support group are currently being recruited.

Resource implications:

2014/15:

- Planned net savings £80,370
- A&E attendance reduction (-41)
- all other activity included in block contract

KPIs (including link to national KPIs):

- Increase adult access to talking therapies
- 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

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 67% diagnosis rate by 2015.
- There are excessive waiting times for people with autism

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 pathway with GP Clinical Leads.

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. Develop community based dementia assessment services by expanding the role of mental health nurses to establish a pro-active approach to clinics in primary care.
- Develop and enable clear pathways of care by using a long term conditions approach to support for people with dementia and their carers and expand the range of local post diagnostic support services.
- 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.
- Autism – Increase contracted activity to meet increased number of referrals and eliminate remainder of waiting list in 2015/16. This will be an interim solution pending agreement of the neuro-developmental pathway.
- 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.

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.

Resource implications:

2014/15:

- Net saving £791,073
- Total activity reductions -796 from MFT and KMPT

KPIs (link to national KPIs)

- Deliver a 67% diagnosis rate for dementia by 2015.
- 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 mutli-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:

- Swale and Medway Community Children's Nursing Service (CCNS) - Develop a new integrated community children's nursing service that offers care closer to home and promotes greater integration between primary care, community based services, local and tertiary acute providers. The service will support children aged 0-19 years with long term conditions, disabilities and complex continuing care conditions (including neonates) and children with life limiting and life threatening illness including palliative and end of life care. This service may also include children's therapy services.
- 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.
- Neural Impairment and Physical Disabilities - Additional investment in OT and physiotherapy to support specific care pathways as part of an improved approach to supporting disabled children and young people with neural impairments and physical disabilities. This will enable the CCG and Local Authority to comply with new joint commissioning duties as detailed in the Children and Families Act 2014. It is possible that this function could be built into the model design of the Community Children's Service scope (i.e. to include therapies as well as nursing within the model).
- Acute Services - Audit of maternity services to ensure that expectant mothers are following, and are coded, on the correct Maternity Payment Pathway. A higher proportion of expectant mothers booking at MFT are recorded on the intermediate pathway than is reported across the region. Additionally, a full review of MFT community paediatric service will be undertaken in order to identify capacity and demand on different aspects of the service . This will identify the content of the block and tariff parts of the contract and will result in the development of up-to-date service specifications which will form part of the MFT contract.
- 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 mult-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:

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: Long Term Conditions including Health Inequalities

Objective:
Swale has the highest levels of deprivation in Kent apart from Thanet. The two highest causes of preventable deaths are CVD and COPD.
The aim of the Health Inequalities programme is to impact the number of deaths from CVD and COPD, reduce life expectancy variation and improve the quality of life for people in the Swale area.
We aim to do this by:

- Raising awareness of the causes of CVD & COPD via the continuation of the Beats and Breathes programme for 2015/16.
- Linking with and providing support for difficult to reach communities.
- Identify GP practice projects that focus on specific areas of Health inequality and support all practices to complete two projects per year.
- 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 Swale including ill health from preventable diseases and significant difference of life expectancy between highest and lowest quintiles (10 years).

Swale CCG has addressing Health Inequalities as one of its key prioritiesThis is supported by the Health and Social Care Act and JSNA for Swale and Kent 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

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.

What did our patients and local population tell us?

Public engagement events are always very well attended and very popular with local communities. The discussions with the general public has been positive and there have been changes in behaviours as a result of the engagement events

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.

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.

Key projects and milestones:

1. Continuation of Beats and Breathes Programme for 2015/16, building upon current feedback:
Practices' awareness and management of patients' disease in line with QOF indicators has shown improvement in delivery in most disease areas but there are still improvements that could be achieved by a systematic approach to individual practices' project work. This project brief content and processes for 2015/16 will be led by specialist nurses and will focus on three specific areas, Heart failure, COPD and AF stroke prevention. There will also be a Public Health indicator project to be completed by all that will systematically update public health status's (smoking, alcohol consumption risk and BMI) for registered patients. A clinical training session for clinical practice staff will be held to ensure the clinical implications of the selected project are understood.
Improved data intelligence will be supplied to GP practices in order for them to understand their local health inequalities status and individual CCG support will be tailored to meet the needs of that practice to help increase the identification of patients needing support for their condition. Non-elective admissions both long and short at MFT are showing a decrease trend.
The public engagement programme has seen approximately patients over 2014/15, providing advice and support with reference to support services for about patients and recommendations to see their GP provided for about patients. – have asked health trainers for 2014/15 data.

2. Review of the current programme, and development and implementation of extended health inequalities programme – Q4 2014/15 will be used for planning and training for implementation of Health Inequality projects from April 2015.

3. Implementation of the Better Care Fund programme, including:
Full Implementation of Integrated Discharge Team this will include Phase 2 roll-out of the Integrated Primary Care Teams, to expand them to include other key providers, including community pharmacy, to further support people with long term conditions both in terms of self-management and in the event of a crisis.
Implement an Integrated Dementia service within the community and rapid response teams
Develop an Integrated Primary Care Teams supporting GP practices, which deliver robust rapid response, geriatrician and physician services, long term condition management, mental health and social care support.
Patients enabled to access their health and social care record and enable key health and social care information to be made available electronically to relevant services

What did our providers and GPs tell us?

Practices that have participated have found patients on their registers that are not correctly identified within the appropriate disease areas. Knowledge gaps have been identified and training implemented.

In addition, GPs have identified the need for improved working with community nursing and social care to provide integrated support for people with long term conditions

Risks and mitigating actions:

Projects identified by practices either inappropriate or inadequate to identify those patients either missing from registers or at risk of getting key preventable diseases.

Public engagement activities only reaching the 'converted' with no follow through or ability to assess effectiveness – links being made with known hard to reach groups and activities being developed through established groups and communication links. Activities leaflet developed to support people – this can also be used to track activities and assess effectiveness of lifestyle changes.

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 comms and engagement work around health promotion messaging will be difficult to quantify.

Potential for an increase in prescribing due to more patients being identified as needing medication to help prevent more serious health conditions.

Workforce implications:

Programme managed by the Assistant Director of Partnerships and Health Inequalities with further support from a project manager. The programme is also supported by 2 part time band 6 specialist nurses and additional Health Trainer support for public events. There is a steering group in place with GP and specialist cardiovascular nurse membership.

Development of Integrated health and social care teams – work in progress with healthcare providers, and social care providers and commissioners to develop service specifications for each team, including identifying the impact on current and future workforce

Resource and activity implications 2015/16:

Planned net saving £147,865

Non elective admission (short and long stay) reduction – 63

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:

100% of practices to increase their QOF disease registers numbers or provide evidence that the audit work has been undertaken and confirmed the low percentage achieved

100% of practices to ensure that 95%+ patients have been seen and annual assessment activities such as blood pressure and cholesterol have been undertaken

100% of practices to have reviewed their patients' medication and disease management regime in line with NICE guidance – evidence to be recorded as part of QOF

All practices to provide a QRisk assessment, providing lifestyle advice and information on support services as require for all patients on their Hypertension disease registers who are not on a CVD, diabetes or COPD register.

National targets:

Securing additional years of life for the people of England with treatable mental and physical health conditions – PYLL (Potential years lives lost) per 100,000

Health related quality of life for people with long-term conditions (measured using EQ5D tool in the GP Patient Survey).

Programme Area: Medicines Optimisation (GP Prescribing)

Objective:
The prescribing of medicines to patients is the most common for of medical intervention in the NHS and the GP prescribing budget is a significant proportion of the overall CCG budget – approx 14%. There are areas of prescribing within the CCG where the prescribing rates and costs are greater than the national average.
The aim of this programme is to reduce variation within the CCG, between practices and closer alignment to the national average in terms of prescribing trends.

Key Drivers for Change:
Within Swale, there is a 68.1% predicted increase in the population ages 65+ from 2011 to 2031 (i.e. from 22,600 to 38,000 people) and this increase is greater in the 85+ group, being predicted to increase 142.3% during the same period (from 2,600 to 6,300).
Older people and people with low socio-economic status have the greatest need to use health services and if the population continues to increase, there will be even greater pressure to prescribe leading to increased pressure on the prescribing budget.
The National Prescribing Centre (NPC) has updated it's document "Key therapeutic topics – *Medicines management options for local implementation*", which list topics in which there is variation in prescribing between CCG's and where there is room to improve prescribing quality and safety. Swale CCG is an outlier in several topics mentioned such as:

- Use of high dose inhaled corticosteroids in asthma
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Antibiotic prescribing – especially quinolones and cephalsporins
- First-choice antidepressant use in adults with depression of generalised anxiety disorder
- Hynotics

What did our providers and GPs tell us?
There are challenges faced by GP's within Swale due to higher than national deprivation levels. There needs to be better communication and working with secondary care colleagues.

What did our patients and local population tell us?
Any changes and alterations to patient's medication need to be communicated effectively and patients need to be supported during such changes.

Key projects and milestones:

- Implement primary care incentive scheme to deliver evidence based prescribing
- Implement new procedures and pathways for the prescribing of Oral Nutritional Supplements (ONS)
- Update and increase the use of the Dressings formulary and ordering process
- Review the need for an IT system for supporting GP's
- Develop community pharmacy services though the implementation of the Healthy Living Pharmacy (HLP) programme
- Implement shared care protocol regarding the provision of Melatonin for children
- Establish a sleep clinic joint with the community Paediatrician team at Medway Hospital

Programme Area: Medicines Optimisation (GP Prescribing)

Risks and mitigating actions:
Practices not engaged with incentive scheme – ensure effective consultation in development of the scheme and timely feedback during the scheme duration
Provider services not engaged to develop new pathways and formularies – Ensure effective project management and clinical leadership, from the Swale Medicines Optimisation Committee (MOC)

Workforce implications:
Identified the need for more capacity within the Medicines Optimisation Team. Extra Technician employed from the beginning of 2015.

Resource implications:

2014/15:

- Planned net savings £660,000

KPIs (link to national KPIs)

- 100% of practices engaged in the incentive scheme (19/20 practices engaged)
- Achieve net saving of £660,000 (November forecast – saving of £630,000)
- MCH dietician service to train/educate care homes/community staff on new ONS guidelines to help decrease spend by 10% - spend has increased by 25% (November data).
- GP/KCHT (community nursing) adherence to dressing formulary to reach a target of 75% (from 50%) – 60% achieved by November.
- Develop and implement Shared Care protocol for licensed Melatonin. Target of 75% prescribing of licensed melatonin (from 5%) – 51% licensed use by November.
- Work with KCC public health to implement the HLP programme in Swale. Target of 10 HLP - 13 pharmacies engaged and staff undergoing training, to be completed by Feb 2015.
- Review appropriate IT support systems for GP use – trial of system to begin in March 2015.