NHS

Ashford Clinical Commissioning Group

Agenda Item 5

Strategic Commissioning Plan

April 2014- March 2019

(Incl. Operational Plan April 2014-March 2016)

v0.4

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A note from the Chair

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

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

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

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

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

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

Increased elective productivity through provision of “Right care, first time, right place” →

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

Integrated 24/7 urgent care system across all sectors →

Reduced acute ambulatory care sensitive emergency admissions →

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

Improved maternity experience particularly early pregnancy →

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

Reduce the number of suicides →

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

Personalised care and independent living for patients with long term needs →

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

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

Governance

- Health and Wellbeing Board
- Programme Boards
- Federation meetings
- Monthly review of programme or project progress at CCG Clinical Strategy and Investment Committee meetings
- Identified Leads CCG for specific projects

Success Criteria

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

Values and Principles

- People are supported to live in their own homes or communities.
- We have a workforce with skills to deliver integrated care.
- Our integrated teams respond rapidly to people at risk of admission
- Carers are be supported and have access to services as appropriate.
- We will have systematised self-care so that people can to manage their own health and social care needs

Introduction

Background and Context

Our Vision

Our Values

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Background and Context

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

This means that 2014-16 will be another challenging period for the NHS and your CCG will be taking to support delivery of the improvements and standards set out in the NHS Constitution (DH 2012), the NHS Mandate (DH 2012) and the NHS Outcomes Framework (DH 2012).

In support of the 2014/16 planning and delivery process ACCG has produced this document to:

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

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

We believe that these steps will deliver ambitious improvements to the local NHS in line with the needs of local people as set out in our Joint Strategic Needs Assessment (2012) and Joint Health & Wellbeing Strategy (2012) as well as against the 5 Domains of the NHS Outcomes Framework:

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

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

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Our Vision

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

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

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

"A Healthcare Partnership to be proud of"

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

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By 2018/19 we want to achieve a health economy that is sustainable for the future. We want care that crosses the boundaries between primary, community, hospital and social care. Our vision is of primary and community care services working closer together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities.

We aim:

1. To deliver the 'right care, in the right place at the right time by the right person' to the individual that needs it.
2. To reduce the pressure on the acute hospitals by ensuring the right services are available and accessible for people when it is required.
3. Wherever possible, to support people to stay well in their own homes and communities.
4. To support people to take more responsibility for their own health and well- being.
5. To get the best possible outcomes within the resources we have available.

What will we have done to achieve vision and aims?

- People will be supported to live in their own homes or communities.
- Access to an excellent General Practice service which, along with the range of community services, proactively seeks to keep people well and healthy in the community but, when appropriately required, can access secondary care services.
- We will have reduced pressure on the acute services.
- We will have integrated our professional teams to have new workforce with skills to deliver integrated care.
- We will have a rapid response integrated team whose task is to respond to people at risk of admission to hospital or residential or nursing home care where indications are that, with some immediate intensive input and support, such admissions can be avoided.
- We will have a joint accommodation strategy, with appropriate range of accommodation available with care for vulnerable adults needing accommodation and care input, including those with dementia, learning or other disability or with mental health needs unable to remain in their home such as extra care housing. Extra care provides the security of having your own home as well as the availability of having care on site.
- Carers will be supported and have access to services as appropriate.
- Easier access to information, advice and guidance will be available.
- We will have improved access to services through single points of access.
- Care will be available locally.

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- We will have systematised self-care so that people with long term conditions can do more to manage their own health and social care needs to prevent deterioration and overreliance on services.
- We will have improved access to a wide range of assistive technology, telecare and telemedicine to complement person based support, offer reassurance and protection and support independence to support people in the community.
- We will have improved integrated IT systems to improve patient / service user care, underpinned by personal health records that can be accessed by the individual.
- We will have improved access to equipment when it is assessed to be required.
- We will have a 7 day a week support services available for those who require it.
- We will have continued to ensure services available are of a high quality
- We will be open and transparent so people will be able to have a dialogue about services available and what might be required locally.
- Access to good transport services.

How are we going to do it?

- We will design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of hospital and care home admissions.
- We will work together to support care homes.
- We will work together to identify people who may require intensive support at home before they go into crisis.
- We will review community services provision within health and social care.
- We will provide intermediate and reablement care to reable people back to a level of independence that meets their need.
- We will commission services to support people in their own homes.
- We will develop an Integrated Urgent Care/Long term conditions Service/centre model.
- We will develop 7 day a week working across all partners.
- We will develop easier access to services.
- We will develop a falls service.
- We will develop an integrated IT system.
- We will improve access to of assistive technology.
- We will develop a joint accommodation strategy.
- We will develop support for carers.

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- We will develop access to transport for vulnerable people who need it to prevent social isolation and access medical appointments.

How will we know we have achieved success?

- Primary and community care services will be working closer together, along with voluntary organisations and other independent sector organisations.
- People will get the 'right care, in the right place at the right time by the right person'. We will measure the success of this by measuring if there has been a reduction in the time people currently spend waiting for a service.
- Pressure on the acute hospitals will reduced, we will see less acute admissions and reduced length of stay.
- We will see more people remaining in their own homes and a reduction in care home admissions taking into account the increase in population.
- More people will be living independently following reablement/intermediate care.

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Our Values

- **Listen.** listening to patients, being responsive and ensuring their thoughts and needs shape the CCG's commissioning decisions and striving to ensure all patients have the best possible experience of the NHS.

- **Collaborate.** Best healthcare is delivered when working together – clinicians, patients, stakeholders and all sections of the community. The CCG will work as one with its stakeholders within the locality and CCGs across east Kent so that we become recognised as a confident organisation that listens, learns and delivers.

- **Be open to change.** As the needs of patients change and new treatments develop the CCG will strive to make sure it always commissions high quality and value for money services.

- **Be realistic about the challenge ahead.** The CCG knows that with the increasing demands on services it needs to deliver sustainable services within the limits of its financial resources. The CCG will be open and honest with all its patients and stakeholders and work closely with them to prioritise our commissioning decisions.

- **Good corporate governance.** Ashford CCG is committed to ensuring that it is effective at understanding the business, can articulate and oversee the delivery of a strong strategic vision, deliver an improved patient experience and is able to demonstrate robust financial control.

- **Respect and dignity.** We value each person as an individual, respect their aspirations, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

- **Commitment to quality of care.** We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

- **Compassion.** We respond with humanity and kindness to each person and give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked.

- **Improving lives.** We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it.

- **Working together for patients.** We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it.

- **Wide Clinical Engagement.** We believe that all clinicians have a part to play in the design and delivery of health services. We will ensure that the experience and knowledge of all clinicians, and best evidence, is used to drive our organisation and decision making.

- **Services close to patient.** Patients want services as close to home as possible. We will listen to patients and strive to commission more community / primary care focused services.

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Working with… **Local GPs**

Detail to follow

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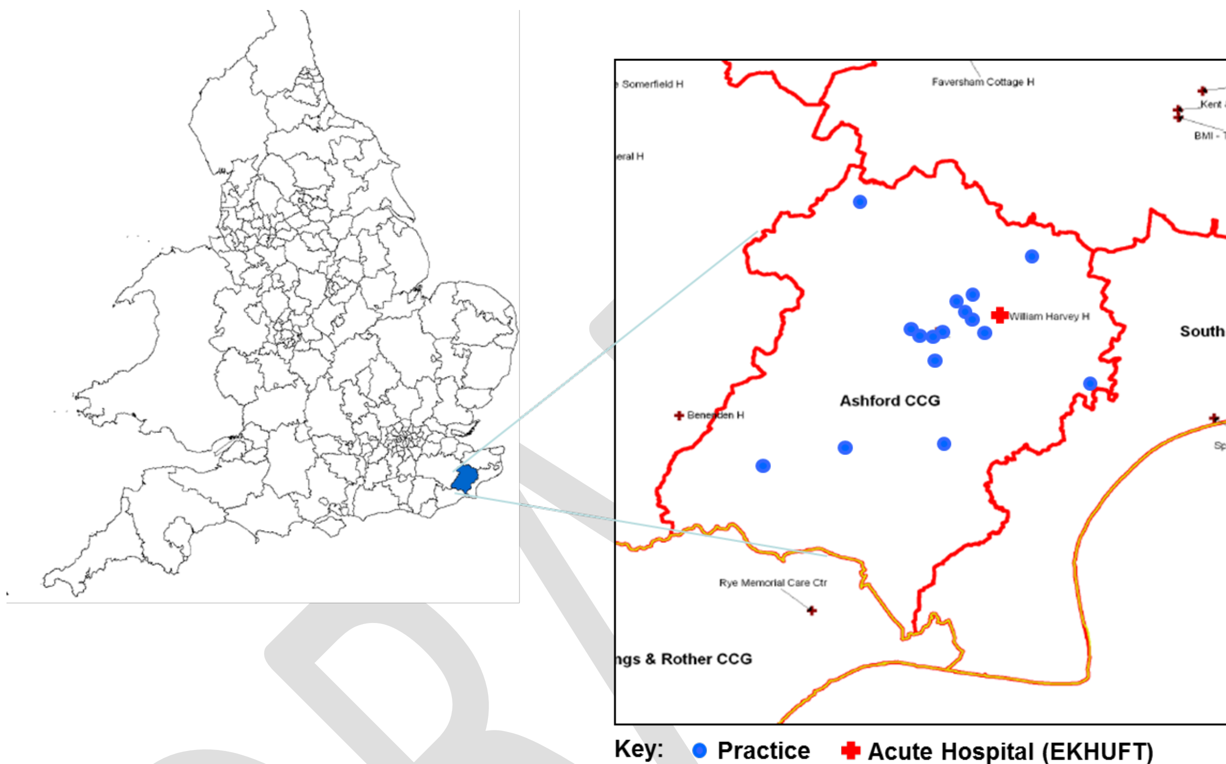
SUMMARY – OUR POPULATION HEALTH CHALLENGES	
Inequalities	The average life expectancy in Ashford is 83.4 years for females compared to males at 80.7 The lowest life expectancy figures are in the wards of St Michaels and Weald East and Weald North, with the highest figures in Park Farm North and Washford.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

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

Location

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



Key High-Level Data

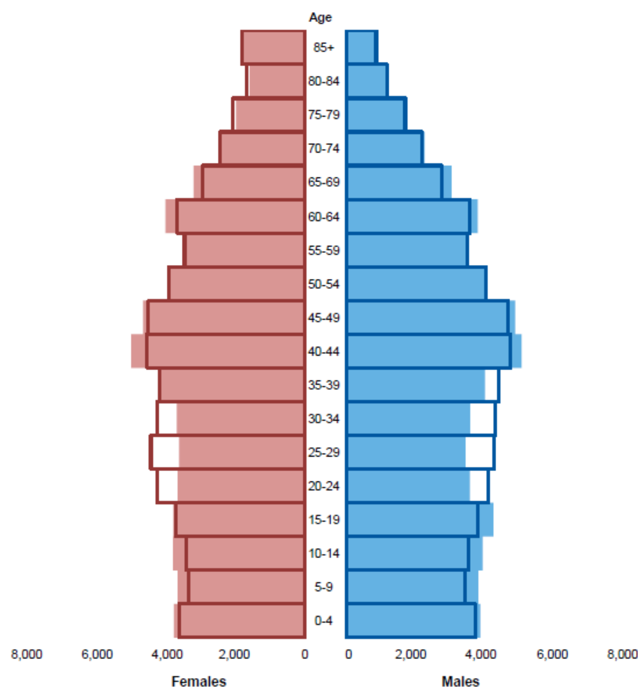
Below are some high-level data points which are relevant to this CCG and its commissioning activity:

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

High-level demographic information

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

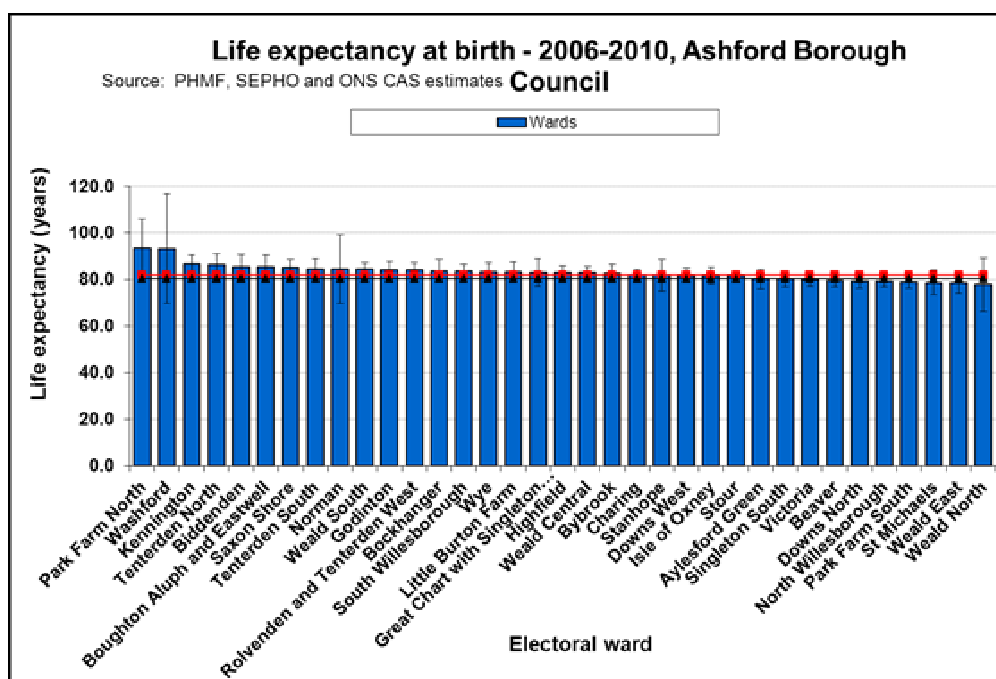
Compared to the rest of England, Ashford has a higher than average population between the ages of 5-14, 40-49 and 60-69. Alongside the importance of health promotion and prevention for the younger generation ACCG must also plan for a 16% rise in 65+ age groups.



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

Life Expectancy

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

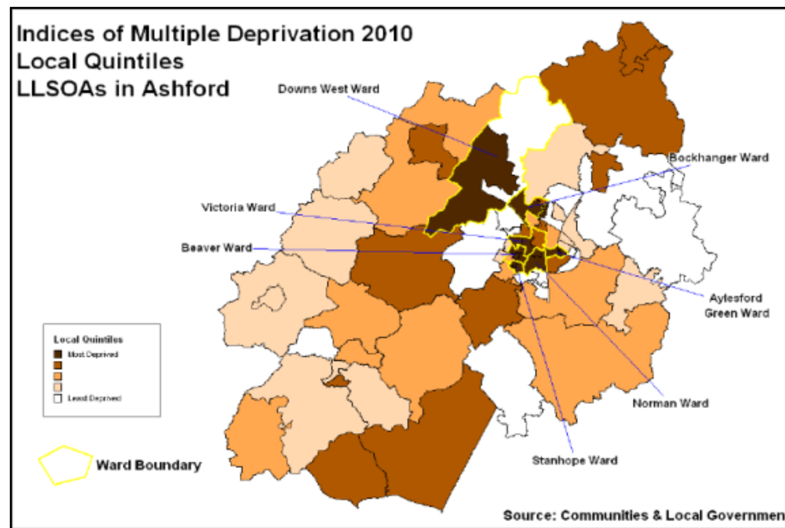


However, whilst ACCG is proud of its current health outcomes it recognises it will need to work hard to maintain the health status and clinical effectiveness of its population particularly with the

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

Deprivation

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



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

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

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

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

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Performance in 2013/14

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Our Plans

Developing Our Plans
Improving Quality and Outcomes
NHS Constitution
Improvement Interventions
Delivery, Efficiency and Risk Assessment

Working with… **Key Providers**

Detail to follow

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Developing our plans

This Strategic Commissioning Plan and the component projects are the product of our ambition to continually improve the quality and patient experience of local health care services.

They build on our experience and robust information and analysis and have been developed in partnership with key partners including Social Care, local Government, our patients, carers and Public Health colleagues.

During the course of the year we have engaged all 22 of our member practices, exploring local needs and inequalities (supported by Public Health). We have also engaged with the public we service, to shape our work plans and set local priorities the outputs of which are summarised in this document.

We are also fully engaged with our Health and Wellbeing Board who have endorsed our vision and plans and the journey they will take the local health and social care system on.

However we recognise that this plan and the projects it sets out, only represent a snapshot in time. It will constantly evolve as we, and our clinical community analyse our system, benchmark our performance, study best-practice and design local services which will deliver a high quality and sustainable NHS for our population.

Improving Quality and Outcomes

We know that we must drive improvements in line with the ambitions set out in the NHS Outcomes Framework and have already identified specific actions against each of the 5 Domains related to quality and safety, these are set out below.

1	**Preventing people from dying prematurely**

DETAIL TO FOLLOW

2	**Enhancing quality of life for people with long-term conditions**

DETAIL TO FOLLOW

3	**Helping people to recover from episodes of ill health or following injury**

DETAIL TO FOLLOW

4	**Ensuring that people have a positive experience of care**

DETAIL TO FOLLOW

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5 Treating and caring for people in a safe environment and protecting them from avoidable harm

DETAIL TO FOLLOW

To achieve the expectations outlined in the domains, NHS England has distilled them into specific measurable ambitions which are critical indicators of success and against which we will track the progress of our plans:

- 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.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

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NHS Constitution

The NHS Constitution identifies a range of standards to which patients are entitled and which we are committed to deliver. We have set out these areas below. We know that to fully deliver services which meet the expectations of local people and their rights as set out within the NHS Constitution; we will have to focus through our work plans.

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% 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%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately) Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%

NHS Constitution support measures

Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%
Referral To Treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waiters
A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations
No urgent operation to be cancelled for a 2nd time
Ambulance Handovers
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

Improvement Interventions

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

We have sufficient evidence for us to adopt radical change across Planned and Unscheduled Care, and that we can, and will, drive improvements in medicines use and by working in partnership with our members, improve Primary Care infrastructure, workforce and services for patients.

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

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

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In 2014-2016 our main work streams are…

- **Urgent Care** – Defined as "the range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis." People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.

  Many patients, through better preventative care, should not need to access urgent care services. In addition patients often experience issues in identifying the best urgent care option to suit their needs. In addition, once they access urgent care services they may find it difficult to be discharged quickly and effectively due to sub-optimal integration of care services.

- **Long Term Conditions** - There are around 15 million people in England with at least one long term condition – a condition that cannot be cured but can be managed through medication and/or therapy. Numbers are expected to rise due to an ageing population and certain lifestyle choices that people make. National guidance has, to date, specifically focused on the need to:
    - Risk profile patients
    - Integrate health and social care teams
    - Systematise supported self-care

  The CCG has made good progress in these areas but recognises the work to do to fully implement and optimise these processes. This work is reflected in the 2014/16 objectives and projects which are complemented by specific, required interventions for certain long term conditions.

- **Maternity Children and Young People - The** Child Health and Maternity commissioning agenda is complex and there are a number of issues and characteristics that require a significantly different approach to other commissioning areas. This includes the requirement to deliver against key statutory responsibilities and work in partnership with local authorities, police and other agencies to improve outcomes for children, young people and their families.

- **Planned Care -** Planned care refers to services where the patient has a pre-arranged appointment. This includes things like being referred by your GP to see a physiotherapist or consultant or being sent for diagnostic tests such as an X-Ray.

  The CCG is committed to working with the organisations who provide planned care services to improve care and to look at different ways of ensuring high quality services that are centred on the patient and are available as close to their home as possible.

- **Mental Health -** Mental health is about how we think, feel and behave. One in four people in the UK has a mental health problem at some point during their lives, which can affect their daily life, relationships or physical health. Mental health disorders take many different forms and affect people in different ways. There is no single cause of mental health problems and the reasons why they develop are complex. Some mental health problems are more common in certain people. For example, women are more likely than men to have anxiety disorders and depression. Drug and alcohol addictions are more common in men, and men are also more likely to commit suicide.

Summaries of each projects provided as an annex

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Efficiency and Risk Assessment

This section provides a summary of the efficiencies planned in 2014-16 together the determined level of risk associated with them. All risk has been assessed using the NHS Sustainability Model (NHS Institute for Innovation and Improvement).

Portfolio	Value	Sustainability	Risk Rating	Adjusted Risk Value
Urgent Care	£			£
Planned Care	£			£
Long Term Conditions	£			£
Maternity, Children and Young People	£			£
Prescribing	£			£
Corporate	£			£
Totals	**£**			**£**

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Working with... **Public Health Kent**

After the Health and Social Care Act was passed and from April 1st 2013, top tier Local Authorities have become responsible for a number of functions that were previously performed by the Primary Care Trusts in England, including Public Health.

Locally services include:

- **Children's health** - Healthy Child programme for school-aged children including school nursing
- **Sexual Health** - Contraception over and above the GP contract Testing and treatment of sexually transmitted infections (excluding HIV treatment) Sexual health advice, prevention and promotion.
- **Public Health Mental Health** - Mental health promotion, mental illness prevention and suicide prevention
- **Physical activity** - Local programmes to address inactivity and other interventions to promote physical activity. The Healthy Club
- **Obesity programmes** - Local programmes to prevent and address obesity e.g. National Childhood Measurement Programme and Weight Management Services
- **Drugs and Alcohol misuse** – including, prevention and treatment
- **Tobacco control** - Local activity, including stop smoking services, prevention activity, enforcement and communication activity
- **Reducing and preventing birth defects** - Population level interventions to reduce and prevent birth defects (with Public Health England)
- **Accidental injury prevention** - Local initiatives such as falls prevention services

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Working across CCGs

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

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

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

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

Fair Society, Healthy Lives

The Marmot Review, published in 2010, highlighted that people with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – "it should become the main focus". Consider one measure of social position: education. People with university degrees have better health and longer lives than those without.

Dahlgren and Whitehead (1991) talk of the layers of influence on health. They describe a social ecological theory to health. They attempt to map the relationship between the individual, their environment and disease. It still stands as the most effective illustration of health determinants and continues to inform the work to of those concerned with understanding and reducing the health inequality gap.

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The first layer includes structural factors: housing, working conditions, access to services and provision of essential facilities. The next layer is social and community influences, which provide mutual support for members of the community in unfavourable conditions. But they can also provide no support or have a negative effect. The final layer is personal behaviour and ways of living that can promote or damage health. –e.g. choice to smoke or not-Individuals are affected by friendship patterns and the norms of their community. Individuals are at the centre with a set of fixed genes. It is worth noting that it is the surrounding influences on health that can be modified, those of structural factors, social and community factors and finally lifestyle choices.

Delivering change which will have the greatest impact on health and social care, and the policy objectives set out in the Marmot Review, therefore requires action by central and local government, the NHS, the third and private sectors and community groups. In this section we reflect on the plans of our partners across the public sector.

Kent Health and Wellbeing Strategy

Good health and wellbeing is fundamental to living a full and productive life. Overall Kent has a good standard of health and wellbeing, but this hides some significant areas of poor health and a wide gap in life expectancy (15 years between the healthiest and least healthy wards in Kent). The overarching Joint Health and Wellbeing Strategy (JHWS) aims to identify the health and social care outcomes that we want to achieve for the people of Kent. The document sets out the challenges we all face, what we are going to do to address them and what we hope to see as a result.

The vision in Kent is to deliver better quality care, improve health outcomes, improve the public's experience of health and social care services and ensure that the individual is at the heart of everything we do.

The JHWS is based on data and evidence in the Kent Joint Strategic Needs Assessment (mentioned previously), the Kent Health Profile 2012, the Kent Health Inequalities Plan plus additional guidance from the Department of Health.

Kent ranks 102 out of 152 county and unitary authorities in the English Indices of Deprivation 2010 (ID2010). This places Kent within England's least deprived third of authorities as a rank of one indicates the most deprived area. However, there are areas within Kent that do fall within the 20% most deprived in England. Overall, Kent suffers the most from barriers to housing and services deprivation and suffers the least from health deprivation and disabilities. 70% of Kent residents describe themselves as being in good health and 16.5% of Kent's population live with a limiting long term illness. Kent's ageing population will place significant pressures on health and social care services.

The strategy takes into account the health and wellbeing challenges facing Kent and the difficult financial situation for public services. It is important we look across organisations in Kent and consider how we may change the way we work together so that we can improve the health and wellbeing of every person in Kent. The Health and Wellbeing Board will champion and work hard on behalf of the residents of Kent to ensure we make these improvements.

We also believe it is important that local communities have a greater role in shaping and influencing services and improving health and well-being in communities. This will be supported by the role of democratically elected members and our local Health Watch (patient representation is an integral part of the Health and Wellbeing Board). Not only do we think this will help us tailor services to meet the needs of local people we also understand the value of community in improving the health and well-being of residents.

Partnership working on health and wellbeing issues is not new in Kent. We have a long history of doing so; the recent establishment of the Kent Health and Wellbeing Board which includes a Health Watch representative, Council representatives and Health representatives will enable even closer working.

This joint health and wellbeing strategy is a new opportunity for the health and wellbeing board members to explore together the local issues that we have not managed to tackle on our own. It sets out collectively what the greatest issues are for the local community, based on evidence in our Joint Strategic Needs Assessment, how we will work together to deliver the agreed priorities and what outcomes we intend to be achieved.

The Health and Wellbeing Strategy informs the Ashford CCG commissioning plans enabling us to focus on the needs of service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment).

From these Priorities and Approaches come 5 key Outcomes against which we will measure our success in improving the health of the people of Kent. These key outcomes are:

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Every Child has the best start in life - Over the next 3 years we would hope to see an increase in breast feeding take up. We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels. There will also be an increase in MMR take up and additional Health Visitors who will support families with young children.

People are taking greater responsibility for their health and wellbeing - This is designed to promote a continued increase in people accessing treatment for drug and alcohol problems; fewer alcohol related admissions to hospital; an increase in people quitting smoking and staying smoke free and more people supported to manage their own conditions.

The quality of life for people with long term conditions is enhanced and they have access to good quality care and support - More patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once); see a 15% reduction in A&E admissions; a 20% reduction in emergency admissions and a 14% reduction in elective admissions. More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected.

People with mental ill health are supported to live well - Early diagnosis of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing. The stigma of mental ill health will be reduced.

People with dementia are assessed and treated earlier - Early diagnosis of Dementia will become the norm, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support including housing, supported housing options and dementia friendly communities will lead to patients being able to stay within their own communities for longer. GPs and other health and care staff will be able to have the appropriate conversations with patients and their families about end of life care.

Ashford Health and Wellbeing Board

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

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

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Better Care Fund

The 'Better Care Fund' (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. Whilst the fund itself does not address the financial pressures faced by local authorities and CCGs, it can act as a catalyst for developing a new shared approach to delivering services and setting priorities.

The BCF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The BCF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the BCF as a significant catalyst for change. The BCF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

The BCF will be a pooled budget which will be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CCGs. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

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Working with... **Kent Police**

One in four people experience a mental health problem at any one time. For the police, this often means that of the victims, suspects, and witnesses they deal with on a daily basis, many will be experiencing mental health difficulties. The police may be first on the scene of a person in a mental health crisis therefore assisting police officers to be able to identify people with mental ill health from the very first point of contact - and getting them the right care - can play a critical role in improving health outcomes and response.

The mental health street triage pilot provides an immediate joint screening assessment aimed at adults aged 18 who have presented in a place to which the public have access, who have been reported via the Police, whose presentation suggests a mental health crisis or those individuals who are known to mental health services who require a welfare check.

The anticipated benefits of this scheme are:

- Reduction in the use of Section 136 of the mental health act
- Improve response to those in mental health crisis
- Improve user experience when in mental health crisis
- Improved outcomes for the individual including timely access to services (primary and secondary care)
- Improved understanding of Mental Health within the Police force

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CQUINS
DETAIL TO FOLLOW

Quality Monitoring
DETAIL TO FOLLOW

Hospital Acquired Infections
DETAIL TO FOLLOW

Never Events
DETAIL TO FOLLOW

Whistleblowing
DETAIL TO FOLLOW

Safeguarding
DETAIL TO FOLLOW

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Working with... **Community Safety Partnerships**

The local Community Safety Partnerships undertook a strategic assessment which involved reviewing performance data from the partner agencies.

They have identified the areas where they will focus for the year ahead and having considered the priority areas of Kent's Police and Crime Commissioner, as well as the Kent Community Safety Agreement, the Partnerships have agreed to focus on the following priority areas during the coming year.

- **Acquisitive Crime** - To enable people living, working and studying in the district to do so without risk of being a victim of theft.
- **Anti-Social Behaviour** - To improve the quality of life for people within the locality.
- **Domestic Abuse** - Improve the health and wellbeing of families and individuals subject to and at risk from domestic violence.
- **Road Safety** - To make the roads of the district safer for road users.
- **Substance Misuse** - To improve the safety and wellbeing of people vulnerable to substance misuse.
- **Violent Crime** - Improve the safety of people within the district who are vulnerable to injury through violence

Allocation Assumptions

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

2 Year Financial Plan

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

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

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Expenditure Assumptions

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

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

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

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

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

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

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

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

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

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

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

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Working with… **Kent Fire and Rescue Service**

A combination of factors can significantly increase the risk of an older person suffering a house fire and often decreases their chances of survival. A vulnerable person is someone who is at higher risk of death or injury in a fire, quite often because of mobility issues, or some other physical or psychological reason. Kent Fire and Rescue Service (KFRS) have a team of highly professional personnel who work closely with social services, mental health teams, local authorities, housing associations and the police to put intervention measures in place, often at very short notice.

KFRS offer a detailed home safety visit and have the following items available:

- Fire retardant bedding packs
- Fire retardant blankets
- Alarms suitable for those with hearing and visual problems
- Cooker switches
- Fire retardant sprays
- Letterbox sealing
- Ashtrays (if you have concerns over someone falling asleep whilst smoking, or for disabled people)
- Natural gas and carbon monoxide alarms.
- Falls assessments

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Delivery Architecture

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

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

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

Conflict of Interest

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

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

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

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

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Patient and Public Involvement

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

www.ashfordccg.nhs.uk/

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

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

Complaints and Compliments

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

We welcome complaints as a valuable means of receiving feedback on the services we commission for the people of Ashford and also on the way we go about our business. The CCG aims to use information gathered from complaints as a means of improving services and the effectiveness of the

organisations. We seek to identify learning points that can be translated into positive action, and where necessary provide redress to set right any injustice that may have occurred.

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

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

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

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

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

Freedom of Information (FoI)

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

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

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

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

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Contractual and Performance Management

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

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

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

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

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

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

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

CQUIN payments

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

For 2014-2016 the CCG has identified areas to start making the change. It is likely that quality payments will be made to providers through the strategic use of the CQUIN arrangements covering the following areas:

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

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

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Decommissioning and Disinvestment

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

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

> ***Disinvestment:*** *This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.*

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

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

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

Equality and Diversity

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

Goal	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities 1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
		1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly
		1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all 1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds
		2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment 2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised 2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and	The NHS should Increase the diversity and quality of the working lives of the paid and	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades

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Goal	Narrative	Outcome
well-supported staff	non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay 3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all 3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.) 3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond 4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination 4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes

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

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Education, Research and Innovation

Innovation Forum
Innovation Challenge Events
Clinical Leadership in Commissioning for GP Trainees

Working with… **NHS England**

Detail to follow

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Innovation Forum

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

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

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

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

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

Together with Canterbury and Coastal CCG we have established an Innovation, through which we can:

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

The objectives of doing this are to:

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

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

Innovation Challenge Events

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

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

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

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

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

Clinical Leadership in Commissioning for GP Trainees

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

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

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

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Project Summaries

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Transformation of Outpatient Services	Planned Care
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • TBA Key Changes • Pre-Referral Advice and Guidance Service • One-Stop Clinics • Improved Triage High Level Benefit Assessment For patients • Appropriate referral to the right clinician • Management of their condition by local clinicians • Reduced attendances in acute settings For GPs • Education resource • Reduces redirection/rejected referrals • Reduction in overall referrals For provider • Only those patients that need to be in clinic are seen • More diagnostic tests, where appropriate, can be completed prior to referral • Improves RTT timelines where redirection of referrals has added delays in the past For CCG's • Confidence that referrals to secondary care are appropriate • Potential for savings where patients are not referred and managed in primary/community care Key Risks • Potential for provider to miscode response and therefore output data maybe of questionable quality • Percentage of referrals avoided provides minimal savings • Engagement with GPs

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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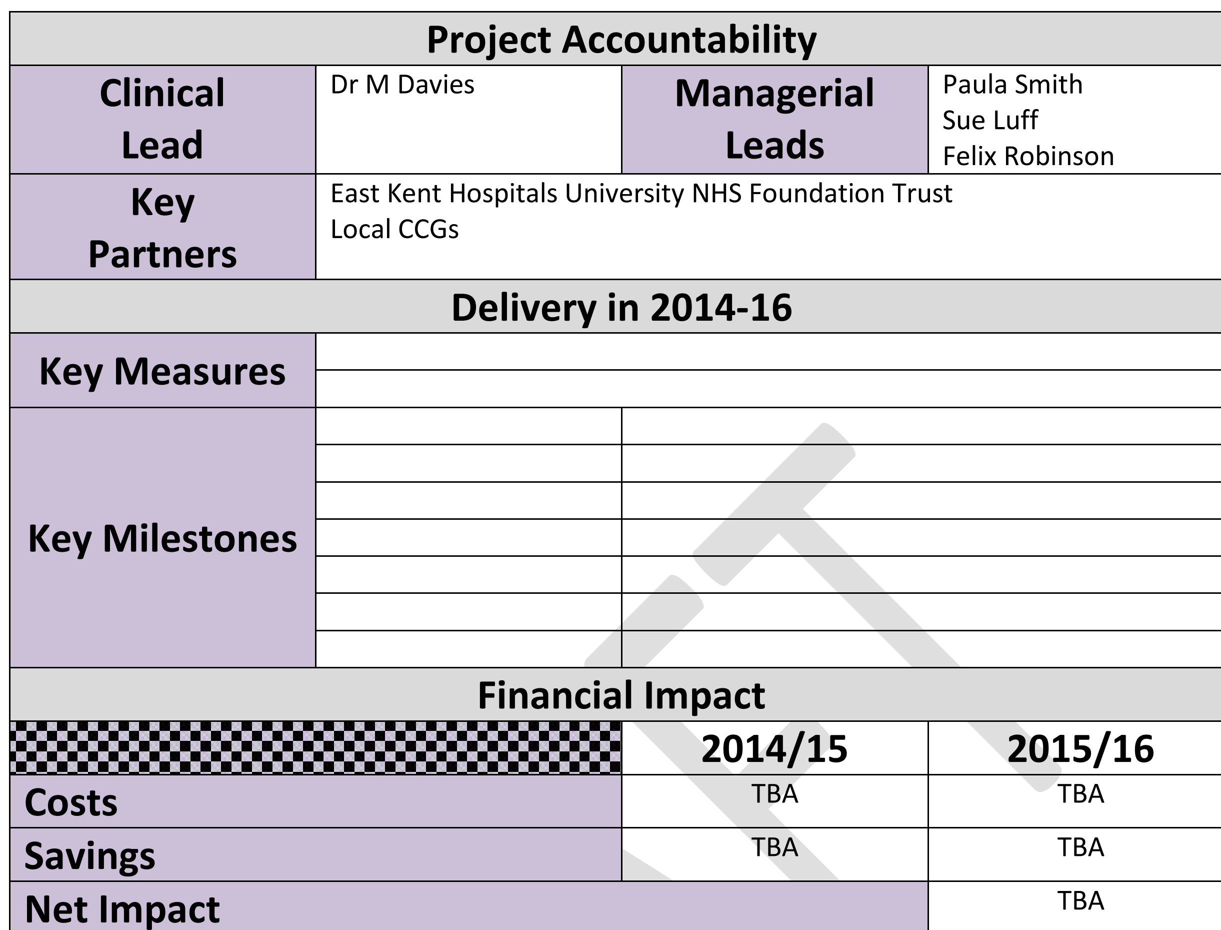

Project Accountability			
Clinical Lead	Dr M Davies	**Managerial Leads**	Paula Smith Sue Luff Felix Robinson
Key Partners	East Kent Hospitals University NHS Foundation Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

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Dermatology	Planned Care
Description	Strategic Fit • TBA Evidence Base • TBA Key Changes • Prime contractor will be responsible for developing and implementing an integrated and coordinated programme of Dermatology care • Services will be commissioned on the basis of "outcome" rather than separate services for each condition. High Level Benefit Assessment • Reducing fragmentation in the patient pathway. • Reducing confusion for GPs with regard to where to refer. • The patient being seen by the right clinician in the right place first time. • Ensuring the right investigations is undertaken. • Creating efficiencies and financial savings. • Better clinical effectiveness and increase quality of service. • Monitoring based on outcomes. • Supports education in primary care. Key Risks • Conflicts of interest from current providers engaged within the Task and Finish Group • Destabilisation of the Trusts Cancer services • Inability to procure a new service by October.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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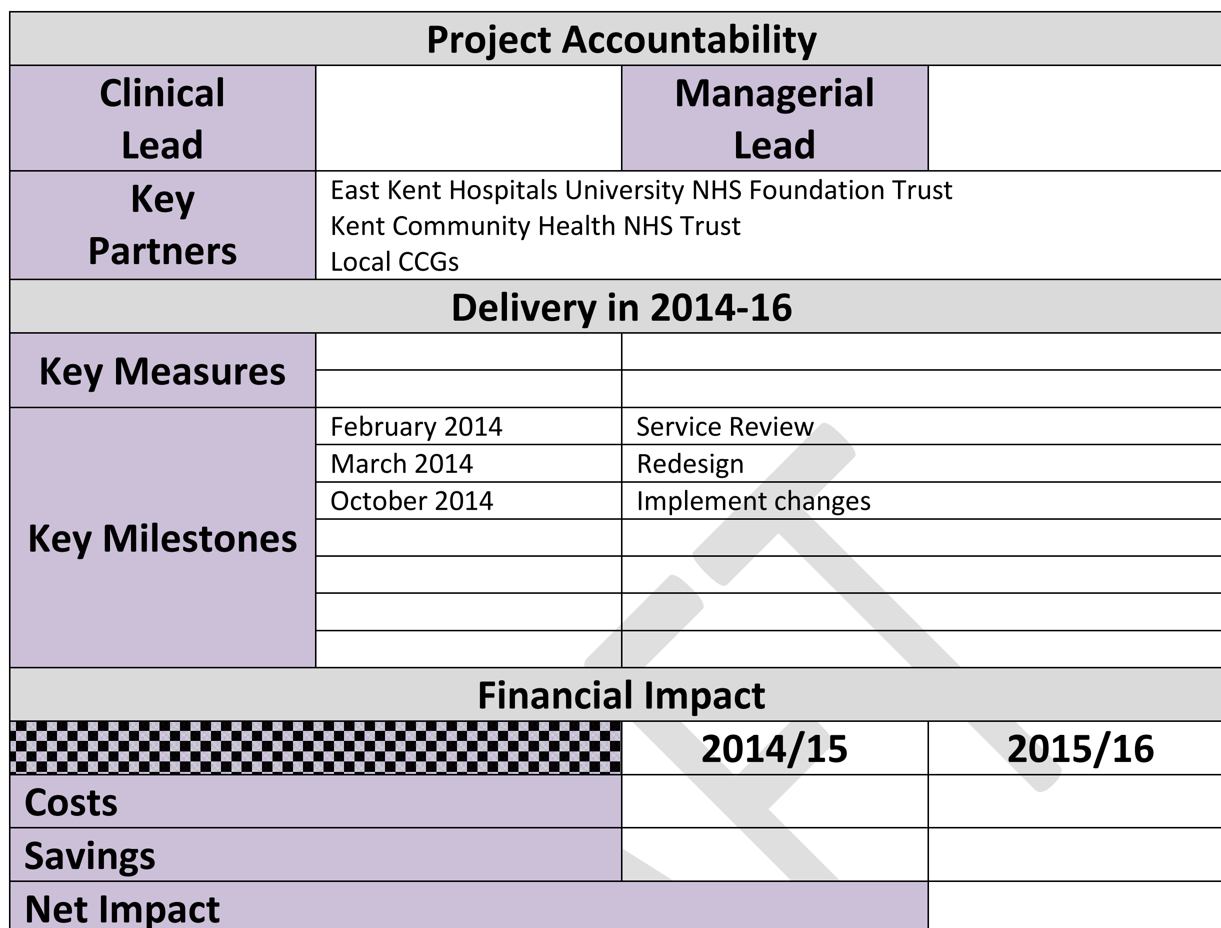

Project Accountability			
Clinical Lead		**Managerial Lead**	
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	February 2014	Service Review	
	March 2014	Redesign	
	October 2014	Implement changes	
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

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Macula Oedema	**Planned Care**

Description

Strategic Fit

- TBA

Evidence Base

- NICE Technology Appraisal Guidance
- Diabetic Macular Oedema (DMO; TA274)
- Wet Age-Related Macular Degeneration (WAMD; TA155)

Key Changes

- A hub and spoke type service model to provide patients with community monitoring facilities and a central acute site(s) for the treatment/drug administration

High Level Benefit Assessment

- Patients would not need to attend acute hospital sites for every appointment.
- Patients seen in a timely fashion and impact on their vision is minimised
- Improved delivery of high quality and value for money monitoring service that will also provide the maintenance a patient requires between injections
- Improved access and choice
- Delivers greater consistency of treatments
- Equity of services across the localities which enhances patient experience and reduces wait times

Key Risks

- Fragmentation of service
- Patients confused where their next treatment will be provided
- Community provider monitoring patients fails to identify developing problems
- Agreed tariff too low to be viable & attract providers

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NHS Outcomes Framework

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

<table>
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<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td></td></tr>
<tr><td>Key Partners</td><td colspan="3">East Kent Hospitals University NHS Foundation Trust
Local Optometrist Committee
Local CCGs</td></tr>
<tr><th colspan="4">Delivery in 2014-16</th></tr>
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<tr><td colspan="2">Savings</td><td></td><td></td></tr>
<tr><td colspan="3">Net Impact</td><td></td></tr>
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Integrated Urgent Care Centre	**Urgent Care**

Description

Evidence Base

- East Kent Integrated Care Pilot 2009
- ECIST review of the Urgent Care System 2010
- Clinical Systems Model for Integrated Urgent Care and Long Term Conditions 2012
- Kings Fund review of Urgent and Emergency Care NHS South of England 2013.

Key Changes

- a clinician to clinician discussion via a 24/7 'Care Co-ordination' Centre;
- enhanced GP out of hours service to replicate what is provided in hours;
- enhanced input to review and treat patients within care homes, reducing the need to access acute hospital services;
- robust decision making skills through the use of jointly developed 'decision support or assessment' tools;
- consistently responsive and reliable service 24/7;
- integration of the out of hours service with other care providers;
- clear discharge processes from urgent care to planned or primary care, to maintain capacity within the system; and
- proactive case management.

High Level Benefit Assessment

- Provide a rapid multi-disciplinary assessment of patients quickly
- Provide rapid access to a range of services that will ensure that patients are managed seamlessly and are better supported to cope within their local community. This service will to prevent a significant cohort of patients from having to attend hospital , improve recovery following an event and ensure that patients retain independence.

Key Risks

- Quality / complaints
- Human resources / organisational development / staffing / competence
- Adverse publicity / reputation

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that 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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Project Accountability			
Clinical Lead		**Managerial Lead**	Alastair Martin
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

DRAFT

Ambulatory Care Pathways	**Urgent Care**
Description	Evidence Base • The Royal College of Physicians – Acute Medicine Task Force & endorsed by the College of Emergency Medicine, 2012 • NHS Elect – Directory of Ambulatory Emergency Care for Adults 2012 • Kings Fund – Managing Urgent and Emergency Activity 2012 Key Changes • TBA High Level Benefit Assessment • Improved access to timely assessment, diagnosis and treatment for patients with Ambulatory conditions • Ability to manage patients within own care setting • Promotes self-management of chronic conditions • Increased patient satisfaction • Integrated service across all providers • Supports development of Integrated Urgent Care System and Community Review • Reduced urgent care admissions Key Risks • TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Luff
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

DRAFT

Dementia Out Of Hours Crisis Support	**Long Term Conditions**

Description

Strategic Fit

- Dementia has been identified as a priority for the Kent HWB as well as the CCG. The business supports the desire to deliver care as close to home as possible.
- The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy, 2009 and the Prime Ministers Dementia Challenge, 2012.

Evidence Base

-

Key Changes

- The proposal is to develop existing community services
- This enhanced service would provide an out of hours response for both older people with functional problems as well as people with dementia
- The service would be available to both patients known to the secondary mental health services and new referrals and would deliver a service to individuals in their own homes, including care homes
- The service will be targeted at those patients requiring an urgent response from mental health services and those patients who needs may require a joint response between community nursing and mental health services because a physical problem has enhanced their level of confusion.

High Level Benefit Assessment

- Enable older people to remain in their own home (which could be a care home) at times of crisis.
- Avoid unnecessary hospital attendances and admissions.
- Facilitate hospital discharge

Key Risks

- Inability recruit to additional posts will impact on service delivery
- Service does not ultimately deliver savings.

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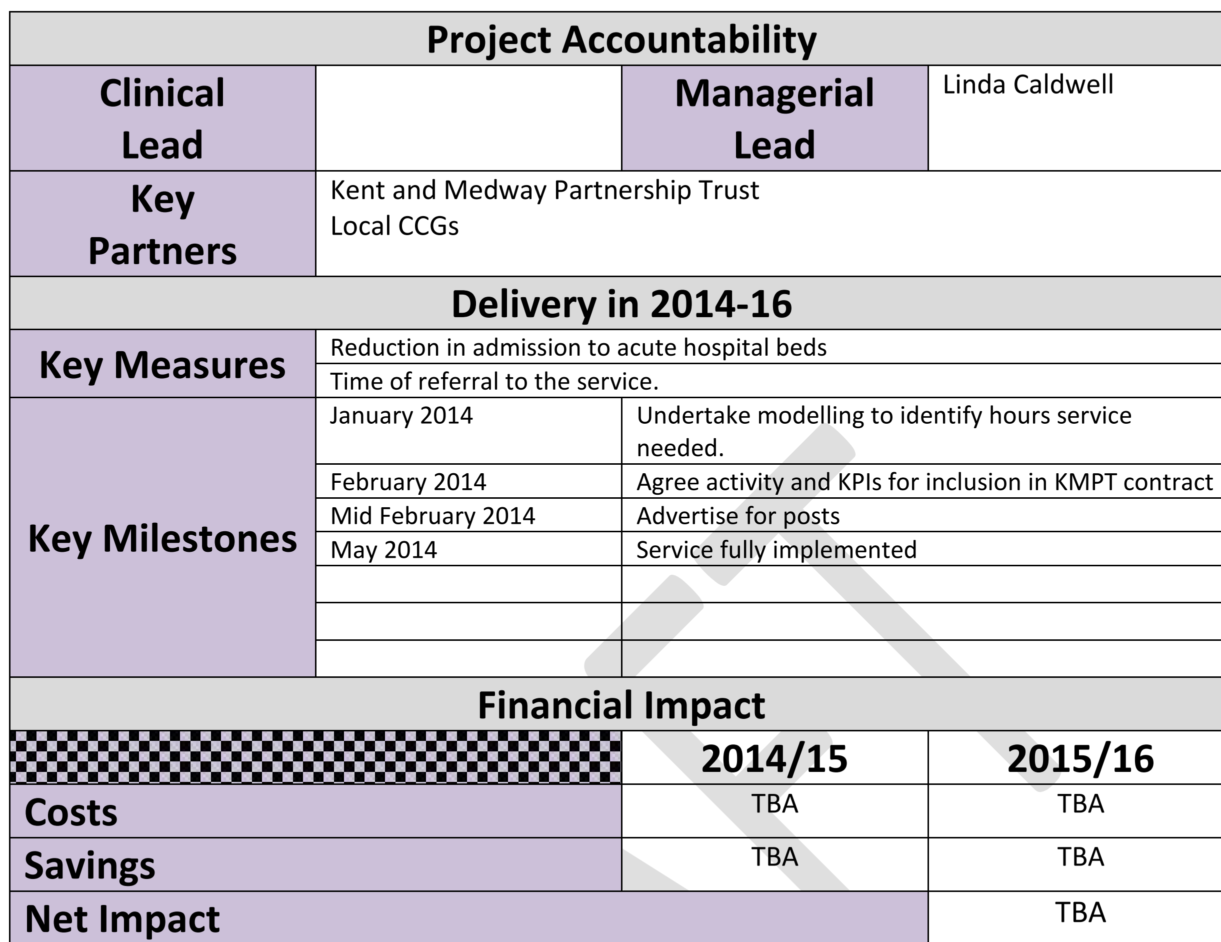
NHS Outcomes Framework

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



Project Accountability			
Clinical Lead		**Managerial Lead**	Linda Caldwell
Key Partners	Kent and Medway Partnership Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduction in admission to acute hospital beds		
	Time of referral to the service.		
Key Milestones	January 2014	Undertake modelling to identify hours service needed.	
	February 2014	Agree activity and KPIs for inclusion in KMPT contract	
	Mid February 2014	Advertise for posts	
	May 2014	Service fully implemented	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

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Pulmonary Rehabilitation Service	**Long Term Conditions**
Description	Strictly see below

Description

Strategic Fit

- TBA

Evidence Base

- TBA

Key Changes

- Increase capacity in the Pulmonary Rehabilitation Service
- Encourage and facilitate patient self-management exercise groups
- Ensure consistency in acute sites operate across East Kent

High Level Benefit Assessment

- Reduced duplication and meet existing gaps in provision – clear patient pathway
- Reduced unnecessary appointments by improving patient self-management
- Equitable service across East Kent
- Closer working relationships between the acute trust and community clinicians
- Accurate Asthma and COPD registers, and achievement of respiratory QoF points

Key Risks

- TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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Project Accountability			
Clinical Lead		**Managerial Lead**	Kim Eaglestone
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

DRAFT

Memory Assessment				**Long Term Conditions**
Description	Strategic Fit • The provision of early diagnosis for people with dementia is identified as an objective in the National Dementia Strategy 2009 • Prime Minister's Dementia Challenge, 2012 which sets a target diagnosis rate of 66% by 2015 (against expected prevalence). Evidence Base • The proposal is based on NICE guidelines. Key Changes • The pathway envisages in future that the majority of people with dementia will be reviewed and monitored in primary care. • Dementia screening should be undertaken in primary care to exclude other reasons for the cognitive impairment • Magnetic resonance imaging (MRI) is suggested as the preferred modality to assist with early diagnosis and detect subcortical vascular changes; the suggestion would be that the scan should be ordered in primary care. High Level Benefit Assessment • Care closer to home by increasing the assessment and treatment available in primary care. • A more multi-disciplinary approach to patients will also help to support the integration of services • Free up capacity in the memory assessment service for those people who need more specialist input Key Risks • Redesign of pathway does not increase capacity in memory assessment services leading to delays in assessment. • Future modelling of local tariffs and activity indicate current budget is insufficient. • Prescribing will continue to be a cost pressure unless appropriate agreements are reached.			
NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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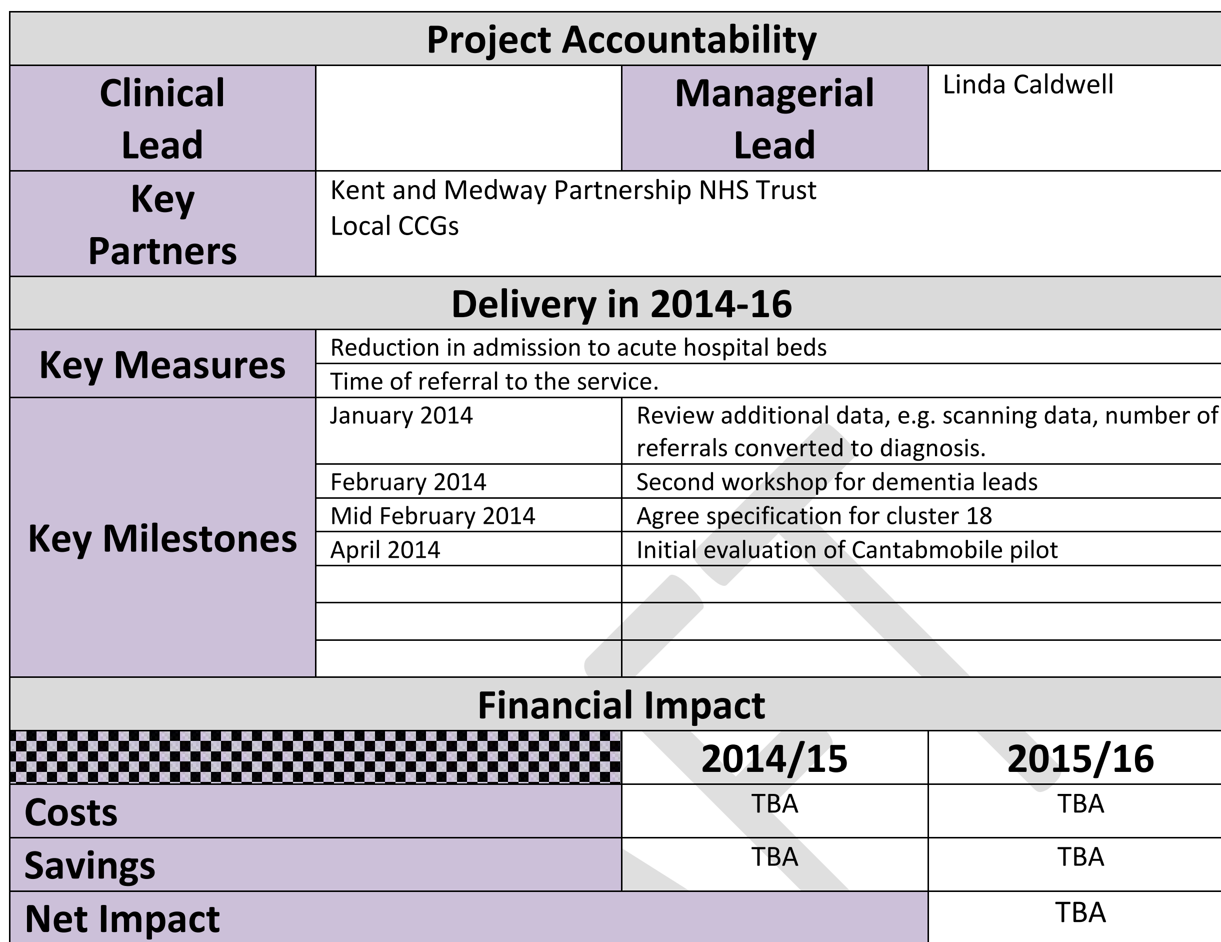


Project Accountability			
Clinical Lead		**Managerial Lead**	Linda Caldwell
Key Partners	Kent and Medway Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures	Reduction in admission to acute hospital beds		
	Time of referral to the service.		
Key Milestones	January 2014	Review additional data, e.g. scanning data, number of referrals converted to diagnosis.	
	February 2014	Second workshop for dementia leads	
	Mid February 2014	Agree specification for cluster 18	
	April 2014	Initial evaluation of Cantabmobile pilot	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

DRAFT

Personal Health Budgets	**Long Term Conditions**

Description

Strategic Fit

- From 1st April 2014 everyone eligible for NHS Continuing Healthcare funding will have a right to ask for a personal health budget
- children in receipt of NHS Continuing Healthcare funding will be affected by the requirement to provide integrated Education, Health and Social Care plans from September 2014

Evidence Base

The final national evaluation of the personal health budget pilot programme was released in May 2013. The key findings of the evaluation were:

- 72.6% of budget holders reported their budget having a positive impact on their independence
- 67.9% reported a positive impact on being supported with dignity and respect
- 67.7% reported a positive impact on being in control of their support
- 63.9% reported a positive impact on their mental wellbeing
- 59.4% of personal health budget holders reported their budget having a positive impact on the long-term condition for which they held the budget

Key Changes

- Implement a robust governance system aligned with the national framework for adults eligible for continuing healthcare
- Implement a robust governance system for assessment and planning linked to the SE7 SEN and Disabled Children Pathfinder and the establishment of the new Education, Health and Care Plans.
- Implement a multi-agency joint commissioning approach to the provision and monitoring of a personal budget.

High Level Benefit Assessment

Benefits to budget holders and carers

- Greater choice and control
- Improved alignment with patients personal life and circumstances

Wider system benefits

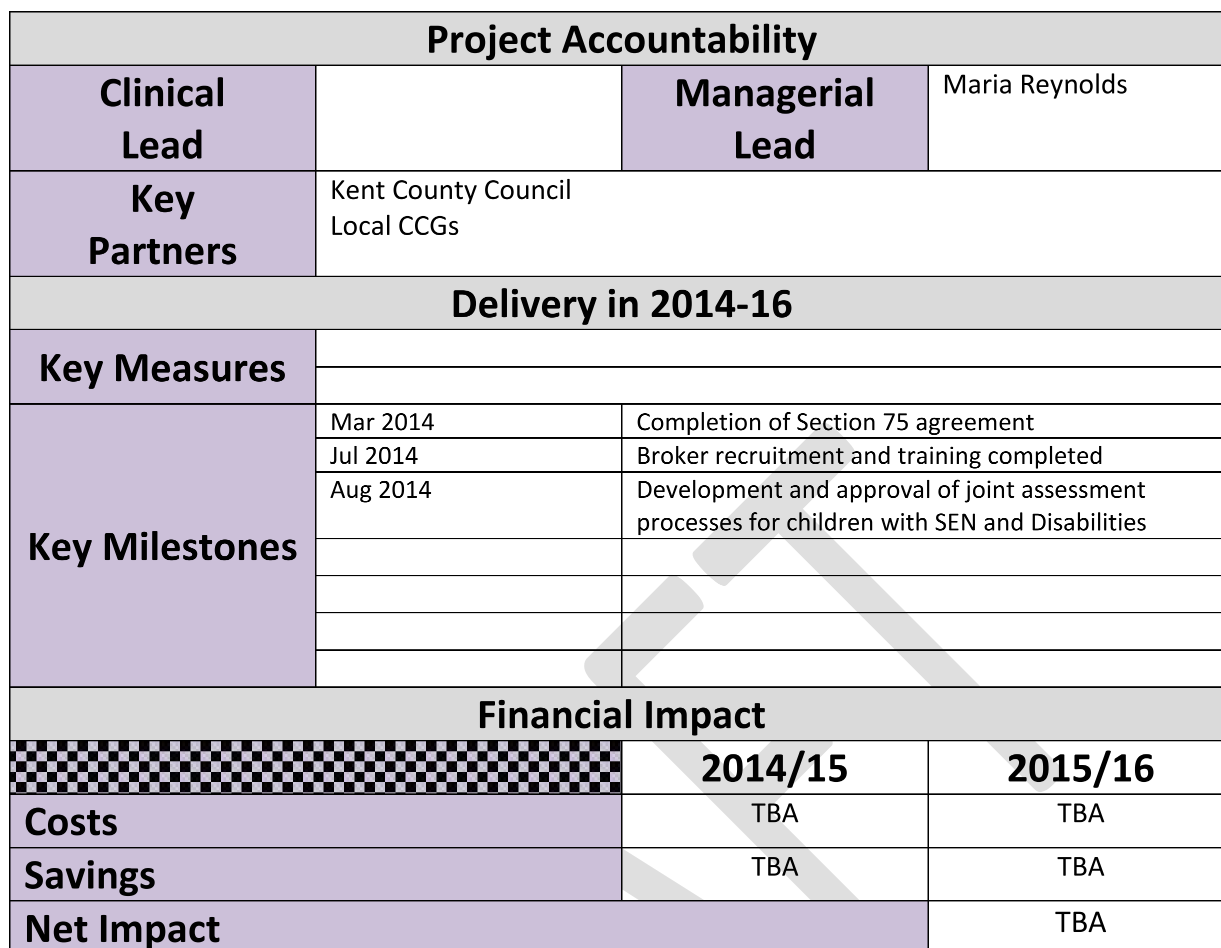
- Greater transparency in the allocation of NHS funds
- Greater integration
- Greater innovation and service development

Key Risks

- Section 75 agreement not completed by April 2014
- Inability to recruit broker resources
- Unable to agree clinical quality monitoring and support with existing providers

NHS Outcomes Framework

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



Project Accountability			
Clinical Lead		**Managerial Lead**	Maria Reynolds
Key Partners	Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	Mar 2014	Completion of Section 75 agreement	
	Jul 2014	Broker recruitment and training completed	
	Aug 2014	Development and approval of joint assessment processes for children with SEN and Disabilities	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Admiral Nursing	Long Term Conditions
Description	Strategic Fit • Dementia has been identified as a priority for the Kent HWB as well as the CCG. • The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy 2009 and the Prime Ministers Dementia Challenge 2012. Evidence Base • NICE QS30 Supporting people to live well with Dementia. Quality Standard 30 (NICE 2012) • NICE CG42 Dementia Support people with dementia and their carers in health & social care (NICE 2005) Key Changes • The existing Admiral Nurse be integrated into the Neighbourhood Care Teams • The service will need to develop stronger working links with Age UK (who currently hold the contract for Dementia Café in Canterbury). • The service will need to link with and harness the expertise, of the link worker aligned to practices to ensure need is identified and referrals made early on. The link worker will also be pivotal in supporting education with regard criteria amongst health professionals. • A combination of clinic and home visit approach is explored and adopted to create capacity, utilising existing voluntary sector accommodation where appropriate (Age UK etc.) • Improve links with carers rapid response and other jointly commissioned services i.e. Crossroads crisis service. High Level Benefit Assessment • Reduced admissions due to carer breakdown Sue Gratton link to crisis service development. (*Patient Safety, Duty Quality, Patient Experience, Prevention)* • Reduced carer admissions • Improved access for carers/families to support them in caring role. • Integrated working between Neighbourhood Care Teams/admiral nursing/voluntary sector • Capacity for service to educate other professionals. • Link to action plan for Dementia Key Risks • TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that 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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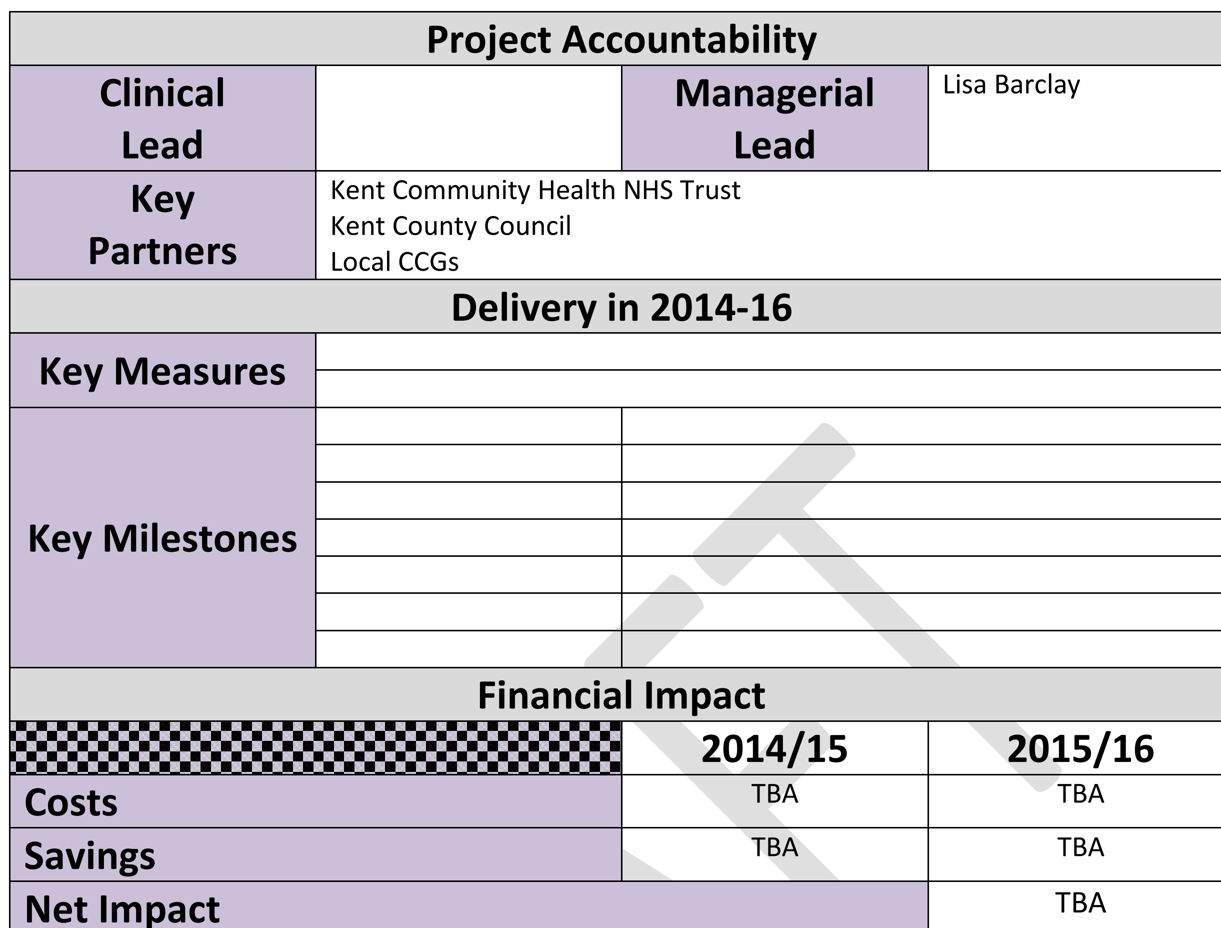

Project Accountability			
Clinical Lead		**Managerial Lead**	Lisa Barclay
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

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Expansion of Neighbourhood Care Team	**Long Term Conditions**
Description	Strategic Fit • Dementia has been identified as a priority for the Kent HWB as well as the CCG. • The provision of good community support for people with dementia is identified as an objective in the National Dementia Strategy 2009 and the Prime Ministers Dementia Challenge 2012. Evidence Base • Neighbourhood Care Team was implemented in February 2013, A&E attendance and admission avoidance achieved in line with plans Key Changes • Make the current H&SCC roles substantive within NCT, recognising the role functions as a central point of access and service navigation for practices. • Review measurement of savings and test cost assumptions on patient cohort where admission avoidance achieved. • Increase the H&SCC roles to cover Sunday between 10-2pm • Extend current NCT team cover for long term conditions, to allow service cover until 8pm at night (currently 5pm), with an on call service being available for care homes 8-8, Mon-Sun • Improve working relationships between Discharge Referral Service and community care to reduce LoS • Encourage use of integrated team through H&SCC, by Out of Hours GP Provider. • Embed use of Share My Care across EKHUFT/KCHT/IC24 and SECAmb to reduce A&E attendances and admissions. High Level Benefit Assessment • Continue to reduce A&E attendances in 65+ age group – absorb growth in population attendances • Improve provider integration Key Risks • TBA

NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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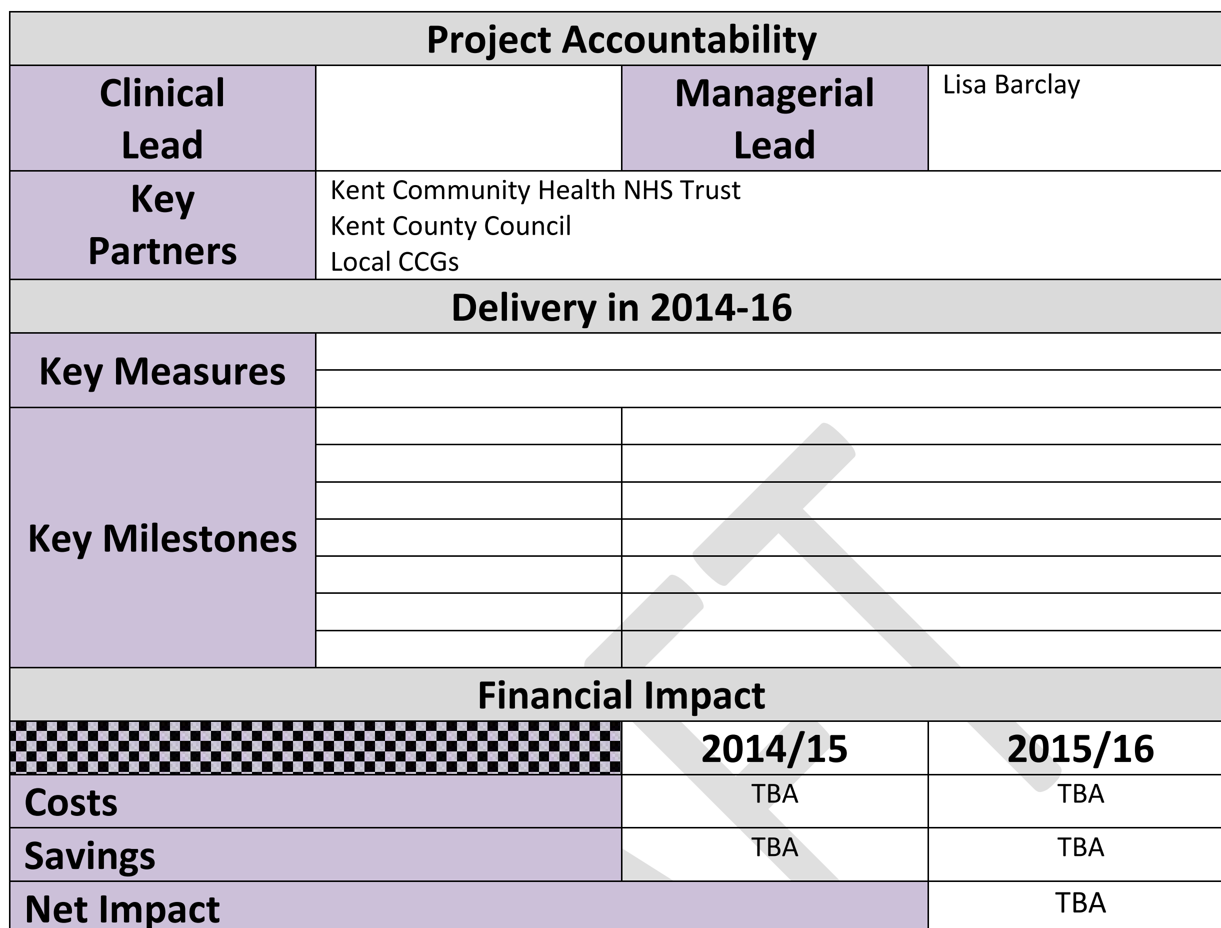

Project Accountability			
Clinical Lead		**Managerial Lead**	Lisa Barclay
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Falls Strategy			Long Term Conditions	
Description	Strategic Fit • Kent has an aging population, the over 65 population is expected to rise by at least 15% over the next 5 years (more than 20% for over 85 years). Evidence Base • One in three people aged 65+ will fall each year and one in two people aged 80+ will fall each year (NHS Confederation, April 2012) • Falls account for approx. 10 to 25% of ambulance callout (NHS Confederation). • NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions Key Changes • Screening of adults who are at a higher risk of falls • Integrated multi-disciplinary assessment for the secondary prevention of • falls and fractures • Use of standardised Multifactorial Falls Assessment and Evaluation tool • across Kent • Availability of community based postural stability exercise classes • Follow on community support for on-going maintenance closer to home High Level Benefit Assessment • Improve access to services • Reduce hospital admissions related to falls by preventing the patient from having a second fall • To reduce the number of health and social care activity related to falls and fracture in older people • Improve patient experience of services • Improve outcomes for patients Key Risks • Public Health timescales for the training and delivery of Postural Stability Instructors may not align with the delivery of the integrated pathway.				
NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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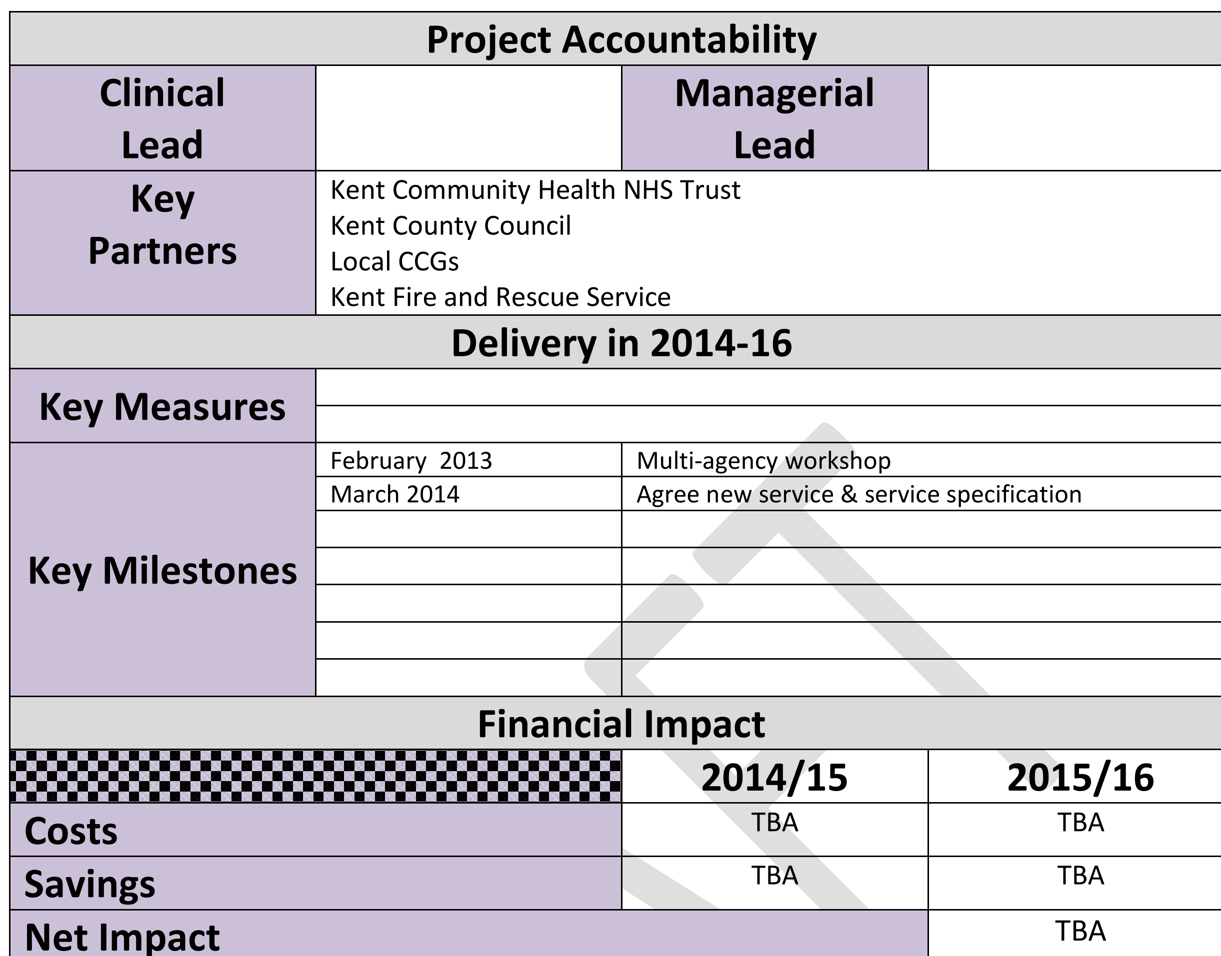

Project Accountability			
Clinical Lead		**Managerial Lead**	
Key Partners	Kent Community Health NHS Trust Kent County Council Local CCGs Kent Fire and Rescue Service		
Delivery in 2014-16			
Key Measures			
Key Milestones	February 2013	Multi-agency workshop	
	March 2014	Agree new service & service specification	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Cardiology	Long Term Conditions
Description	Strategic Fit • Kent Health and Wellbeing Strategy • Joint Strategic Needs Assessment Evidence Base • TBA Key Changes • Review all of the existing services • Develop an integrated service model • Services commissioned on the basis of "outcome" rather than separate services for each condition • Care delivered in a community setting • Clear and responsive referral routes into secondary care services. High Level Benefit Assessment • Reducing fragmentation in the patient pathway. • Reducing confusion for GPs with regard to where to refer. • Ensuring the patients areseen by the right clinician in the right place first time. • Creating efficiencies and financial savings, providing value for money against existing services • Better clinical effectiveness and increase quality of service. • To improve health outcomes through earlier diagnosis and treatment of common cardiology conditions • To reduce the number of referrals, so far as clinically appropriate, to secondary care • To establish a robust communication mechanism between all parties providing and receiving the service. Key Risks • KCHT may not wish to support the continuation of the GPwSI service on an interim basis • Lack of data on the GPwSI service to review effectiveness • Clinicians ability to dedicate time to the Task and Finish Groups

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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Project Accountability			
Clinical Lead		Managerial Lead	
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	2015/16
Costs			
Savings			
Net Impact			

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Community Equipment Loan Store	**Long Term Conditions**

Description	Strategic Fit • TBA Evidence Base • TBA Key Changes • Integrated tender and procurement approach and process for a single Kent wide provider for the Community Loan Equipment Service • Predicted cost pressures for 2014/15 are addressed as part of the KCHT block contract negotiations • in-year improvements to the current Community Equipment Loan Store (CELS) Service provided by KCHT by introducing 7 day working High Level Benefit Assessment • TBA Key Risks • TBA

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that 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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<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Kim Eaglestone</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent County Council
Kent Community Health NHS Trust
Local CCGs</td></tr>
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<tr><td rowspan="2">Key Measures</td><td></td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td rowspan="7">Key Milestones</td><td></td><td colspan="2"></td></tr>
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<tr><th colspan="4">Financial Impact</th></tr>
<tr><td colspan="2"></td><td>2014/15</td><td>2015/16</td></tr>
<tr><td colspan="2">Costs</td><td></td><td></td></tr>
<tr><td colspan="2">Savings</td><td></td><td></td></tr>
<tr><td colspan="3">Net Impact</td><td></td></tr>
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Confidential Inquiry into the Deaths of People with Learning Disabilities (CIPOLD)	**Learning Disabilities**

Description

Strategic Fit

- CIPOLD was commissioned in 2010 as recommended by Sir Jonathan Michael in the 2008 report Healthcare for all
- In response to CIPOLD Kent held a workshop which found that there is scope to implement some of the recommendations locally

Evidence Base

- CIPOLD provides the evidence that people with learning disabilities do not have equal access to good healthcare.

Key Changes

- Mandatory Mental Capacity Act Training for all healthcare providers in Primary and secondary care should be demonstrated as being completed on an annual basis.
- Continue to provide LD training which meets LD DES criteria on an Annual Basis during PLT sessions.
- Improve links with outside LAs who place people in Kent through Care Management to reduce inequalities in health due to lack of system communication – GPs to flag people from out of Kent with their Liaison Nurse to follow up
- Invest in Community Speech & Language in order to reduce hospital admissions due to Dysphagia complications (separate Kent wide Dysphagia business case).
- Address or support Kent wide investigation and review into inequality in access to and use of specialist equipment between CCGs with Kent wide solutions.

High Level Benefit Assessment

- TBA

Key Risks

- TBA

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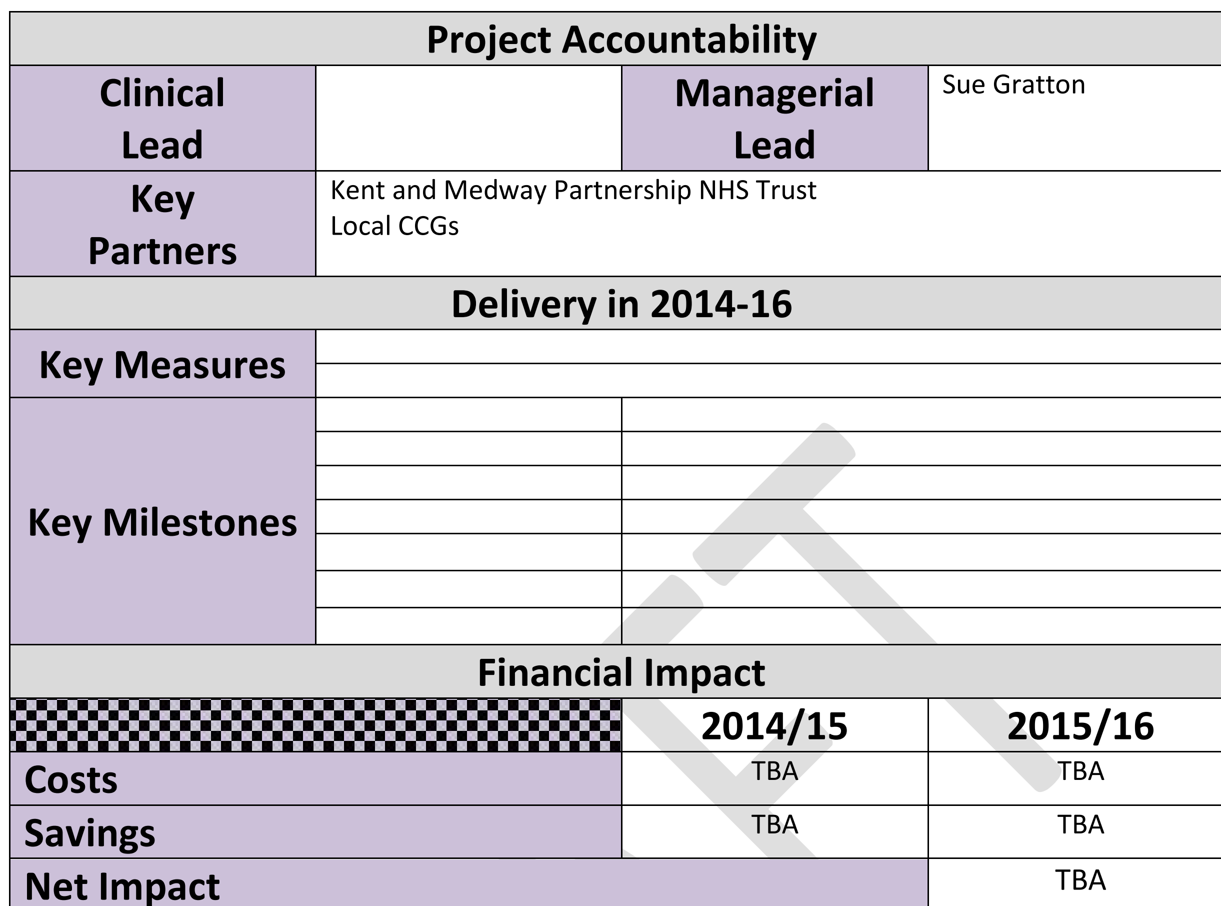
NHS Outcomes Framework

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



Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Gratton
Key Partners	Kent and Medway Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

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Winterbourne Joint Plan	**Learning Disabilities**

Description

Strategic Fit

- The *Winterbourne Concordat: Programme of Action* (DH 2012)

Evidence Base

- The *Winterbourne Concordat: Programme of Action* (DH 2012)

Key Changes

- Agree a personal plan for each individual that is inappropriately placed in CCG or NHS England commissioned learning disability or autism in-patient services and put the plans into action so that all individuals receive personalised care and support in the community no later than 1 June 2014
- Put in place a locally agreed joint plan for high quality care and support services by April 2014, which accords with the model of good care to ensure that a new generation of inpatients do not take the place of people currently in hospital.

High Level Benefit Assessment

- People with learning disability and autism who have complex mental health or behaviour problems will experience more integrated care and support in the community

- There will be improved multi-disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- There will be reduced reliance on the use of high cost in-patient services
- Clinical consultancy and support would be available for other professionals in mainstream services to enable them to make reasonable adjustments.
- The service would meet key requirements of national policy and guidance.

Key Risks

- Lack of funding from NHSE Specialised Commissioning renders commissioning recommendations unaffordable for CCGs and Local Authority
- June 2014 deadline for discharges of current in-patients not met due to requirement to undertake procurement process for new services

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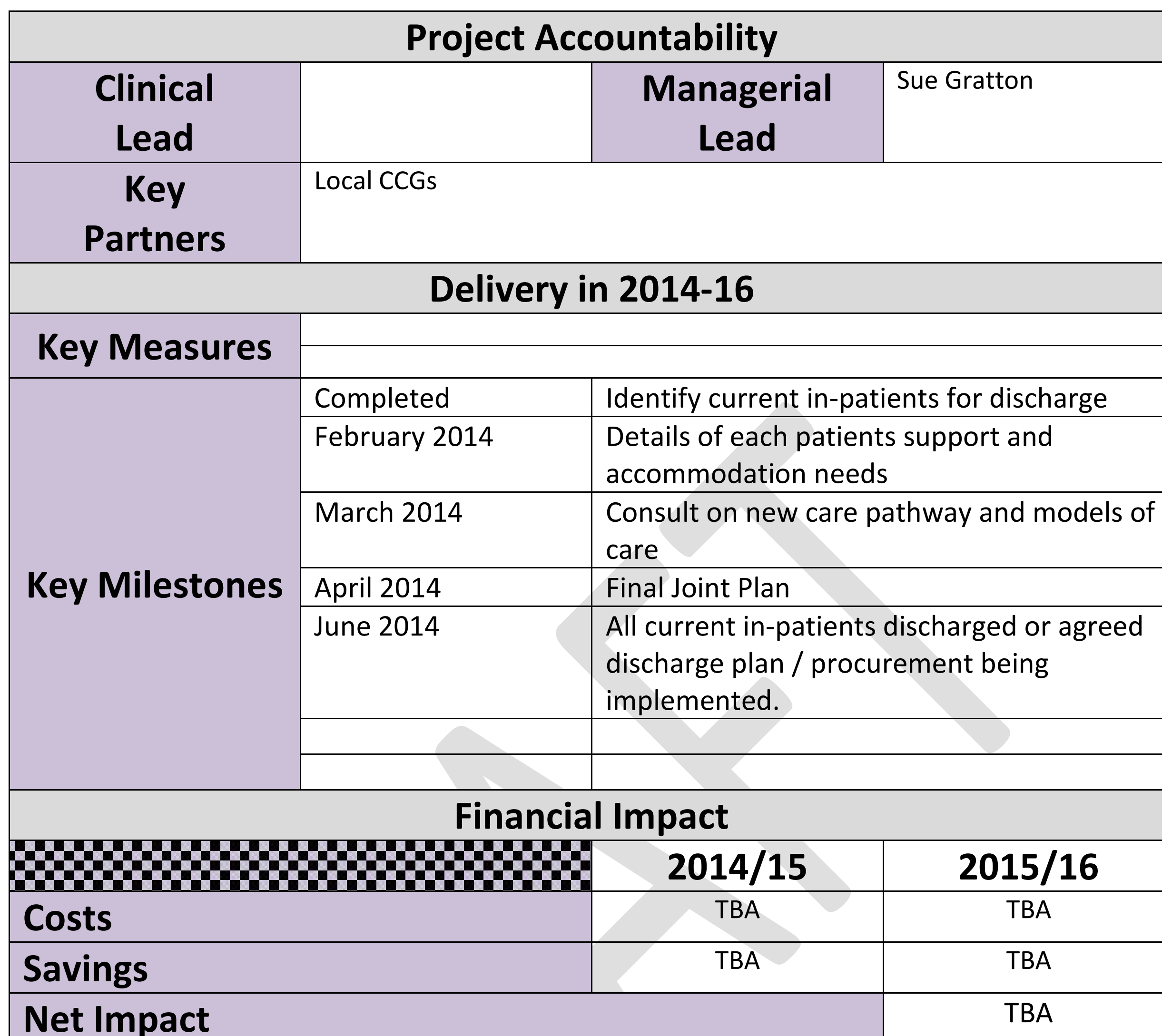
NHS Outcomes Framework

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



Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Gratton
Key Partners	Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	Completed	Identify current in-patients for discharge	
	February 2014	Details of each patients support and accommodation needs	
	March 2014	Consult on new care pathway and models of care	
	April 2014	Final Joint Plan	
	June 2014	All current in-patients discharged or agreed discharge plan / procurement being implemented.	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Autistic Spectrum Conditions Diagnostic Assessment Service	**Learning Disabilities**

Description

Strategic Fit

- It was identified in 2010 that there was no clear diagnostic or care pathway for adults with high functioning autism and Asperger's syndrome in Kent
- The current capacity of the service is 60 diagnostic assessments a year, and the waiting list as of July was 280 patients

Evidence Base

- NICE quality standards

Key Changes

- Increase capacity for assessment service

High Level Benefit Assessment

- The backlog of people waiting for diagnostic assessment will be addressed
- There will be improved multi-disciplinary working including the provision of joint health and social care assessment meetings and specialist interventions
- Formal diagnosis ensures individuals are not referred to inappropriate health, social care and community and voluntary services.
- Carers and families will have a greater understanding of autism as a result of the development of this service.
- The service would meet key requirements of national policy and guidance.

Key Risks

- A legal challenge that the CCG and Local Authority has not met the requirements of the Autism Act to provide easy access to assessment and diagnosis.
- Risk that current level of referrals may not be a true representation of future demand for service – the prevalence data suggests referrals could continue to increase
- Risk that current provider cannot sustain current service which may pre-empt closure of the current service.

NHS Outcomes Framework

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

DRAFT

Project Accountability			
Clinical Lead		**Managerial Lead**	Sue Gratton
Key Partners	Kent County Council Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

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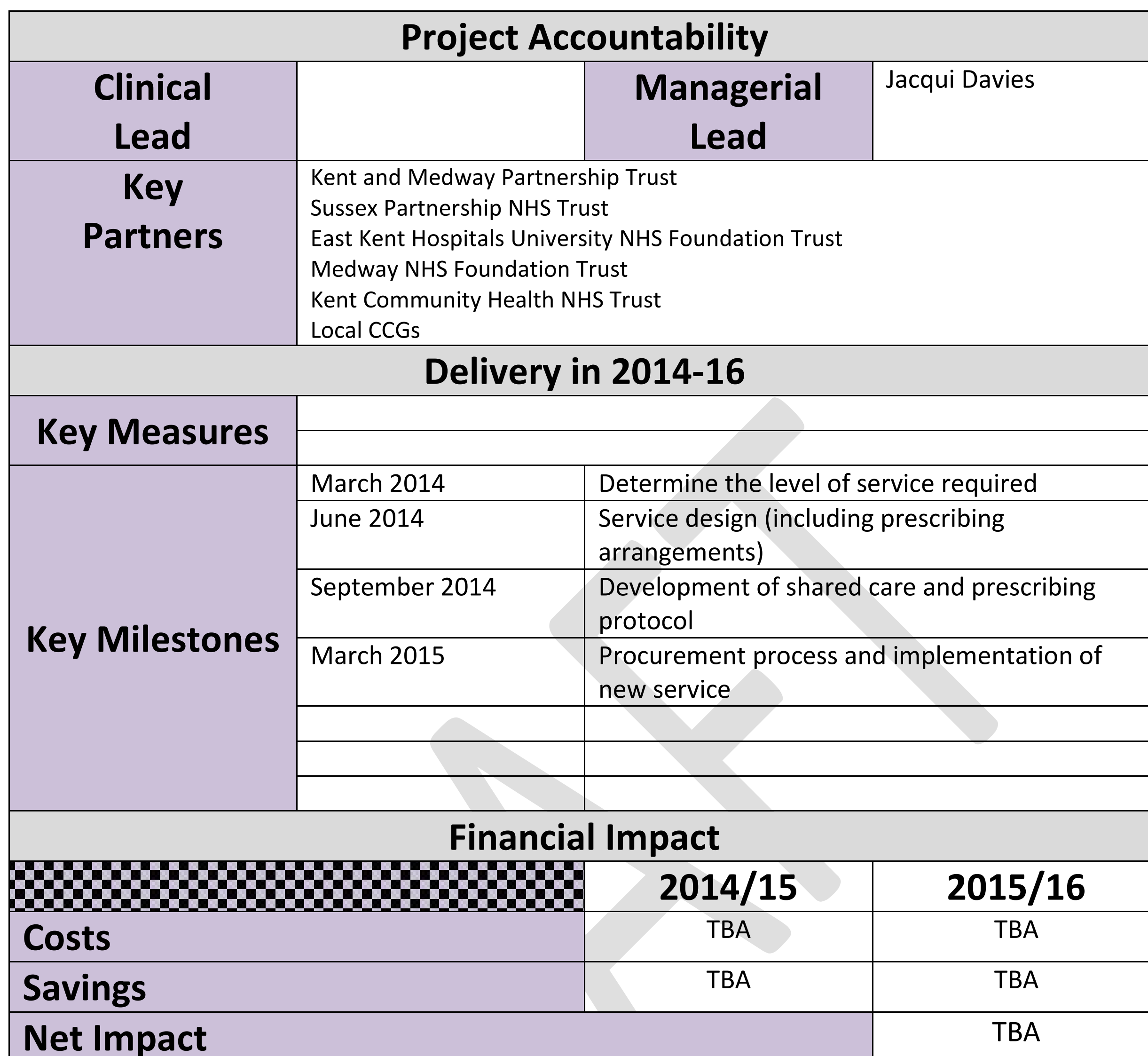
Transformation of ADHD Service	**Mental Health**
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • NICE Clinical Guidance for ADHD 2008 • Joint Strategic Needs Assessment Key Changes • Implement protocols around prescribing, shared care and transition • Provide an integrated, all age, service High Level Benefit Assessment *For patients* • clear pathway • access to a comprehensive treatment programme • access to services in primary care *For GPs* • Shared care and prescribing protocol • Access to specialist service for advice Key Risks • GPs unwilling to sign up to an ADHD shared care and prescribing protocol • Lack of engagement and buy in to the transformation of services from stakeholders particularly at the early stages of the children's pathway

NHS Outcomes Framework

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



Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	Kent and Medway Partnership Trust Sussex Partnership NHS Trust East Kent Hospitals University NHS Foundation Trust Medway NHS Foundation Trust Kent Community Health NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	March 2014	Determine the level of service required	
	June 2014	Service design (including prescribing arrangements)	
	September 2014	Development of shared care and prescribing protocol	
	March 2015	Procurement process and implementation of new service	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Personality Disorders Service	**Mental Health**
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • NICE guidelines for Borderline Personality Disorder Key Changes • TBA High Level Benefit Assessment • *TBA* Key Risks • No increase in current PD service provision – no decrease in current pressures placed by PD patients on A&E, primary care, acute and secondary mental health services

NHS Outcomes Framework				
1	**2**	**3**	**4**	**5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that 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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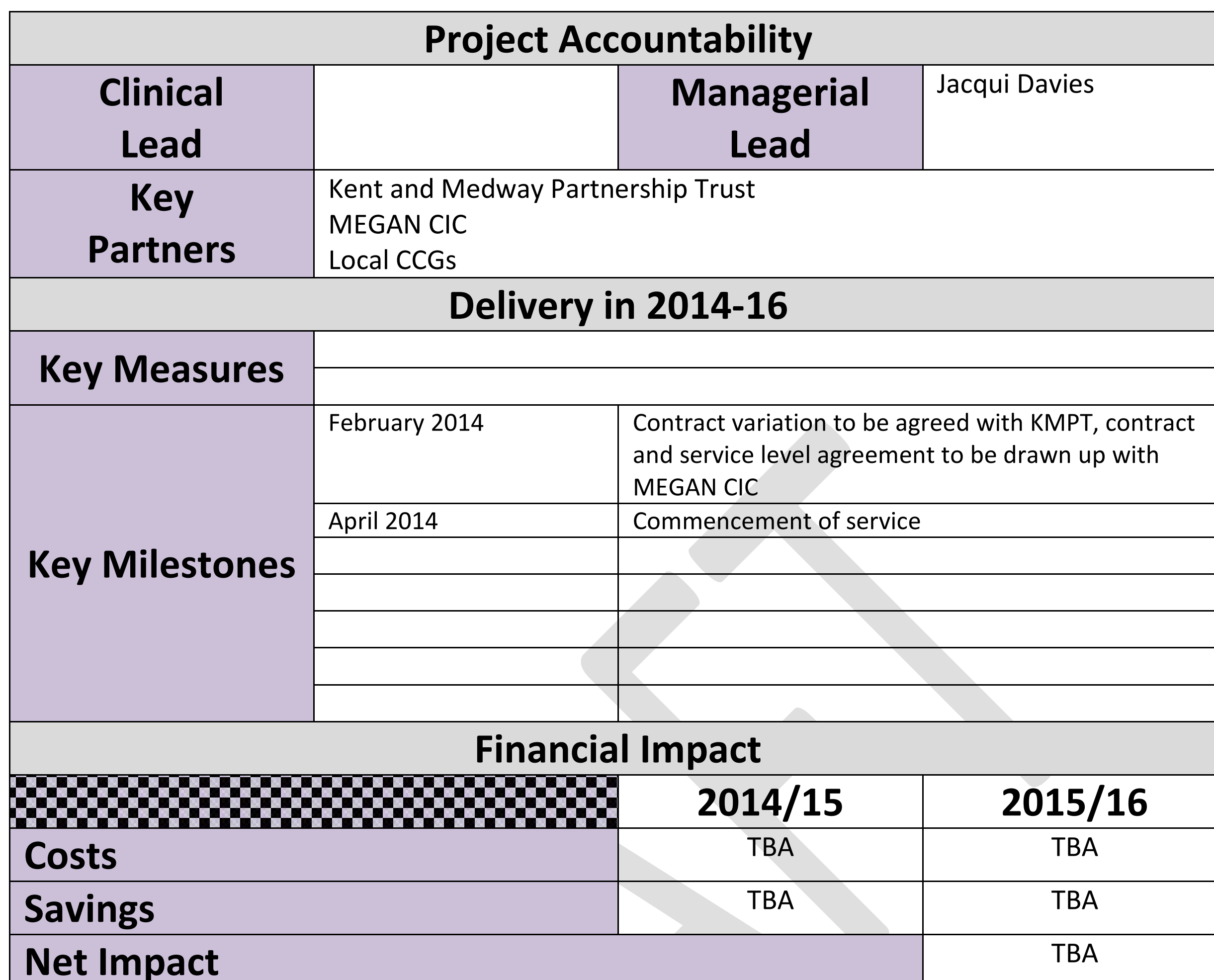

Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	Kent and Medway Partnership Trust MEGAN CIC Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	February 2014	Contract variation to be agreed with KMPT, contract and service level agreement to be drawn up with MEGAN CIC	
	April 2014	Commencement of service	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

Eating Disorders Service	**Mental Health**
Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • NICE guidelines for Borderline Personality Disorder Key Changes • TBA High Level Benefit Assessment • To improve the condition of patients with eating difficulties or disorders, whereby they are able to maintain their physical and psychological health either with no or less specialist assistance • To improve the nutritional health of patients with eating difficulties or disorders • A reduction in subjective distress of patients • To liaise with secondary and tertiary care providers to provide appropriate and timely care for patients identified as needing more intensive treatment or admission Key Risks • Derogation of funds from NHSE to CCGs – no agreement in place between CCGs regarding fair share of funding and resources

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	Helping people to recover from episodes of ill health or following injury	**Ensuring that 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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<table>
<tr><th colspan="4">Project Accountability</th></tr>
<tr><td>Clinical Lead</td><td></td><td>Managerial Lead</td><td>Jacqui Davies</td></tr>
<tr><td>Key Partners</td><td colspan="3">Kent and Medway Partnership Trust
Local CCGs</td></tr>
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<tr><td colspan="3">Net Impact</td><td>TBA</td></tr>
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Transformational of Urgent Care for Children and Young People	**Child Health and Maternity**

Description

Strategic Fit

- Kent Health and Wellbeing Strategy

Evidence Base

- DH and DfE, Improving Children and Young People's Health Outcomes – a system wide response (2013)
- RCGP in partnership with RCPCH and RCN, Commissioning a good child health service (2013)
- Standards for children and young people in emergency care settings (2012)
- NHS Institute for Innovation and Improvement, Focus on: Children and Young People Emergency and Urgent Care (2010)

Key Changes

- New urgent and emergency care clinical network for children and young people
- Use of assistive technology
- Working with Public Health and the School Nursing Service to deliver key messages in schools.
- Develop lesson plans for use in schools around PSHE.

High Level Benefit Assessment

- Parents have an increased level of awareness and confidence in being able to support their children with common illnesses which may require urgent or emergency care.
- Children and young people, where it is clinically safe are treated and supported outside of hospital in their local community.
- Reduction in A&E attendances.
- Reduction in 0 LOS non elective emergency admissions

Key Risks

- Destabilisation of services
- Lack of engagement
- Services not streamlined
- Efficiencies and quality not meeting expectations

NHS Outcomes Framework

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

DRAFT

Project Accountability			
Clinical Lead		**Managerial Lead**	Martin Cunnington
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent Community Health NHS Trust Kent County Council Sussex Partnership NHS Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones			
Financial Impact			
		2014/15	**2015/16**
Costs			
Savings			
Net Impact			

DRAFT

Early Pregnancy Assessment Unit	**Child Health and Maternity**

Description

Strategic Fit
- Kent Health and Wellbeing Strategy
- Kent's Children and Young People's plan 'Every Day Matters'
- Kent Health Inequalities Action Plan "Mind the Gap"

Evidence Base
- NICE Guidelines for Ectopic pregnancy and miscarriage

Key Changes
- Ensure pathways are transparent, equitable and clearly communicated
- Single Point of Access (SPA) led by a clinician who will feed into primary care and OOH services that link to the A&E pathways.
- Improved access to scanning appointments, or explore having a scanner available in primary care

High Level Benefit Assessment
- Ensure the right care is given at the right time, at the right place and by the right professional
- Deliver the best, proactive care to prevent avoidable complications and interventions. Supporting the reduction of adverse outcomes of pregnancy
- Enable and empower women and GPs to use appropriate access routes to the services
- Improve transparency and accuracy of coding to result in more efficient use of resources
- Continued reduction of A&E attendances – improve pathways and reduce activity though this route

Key Risks
- Destabilisation of services
- Lack of engagement
- Projected benefits are not fully realised.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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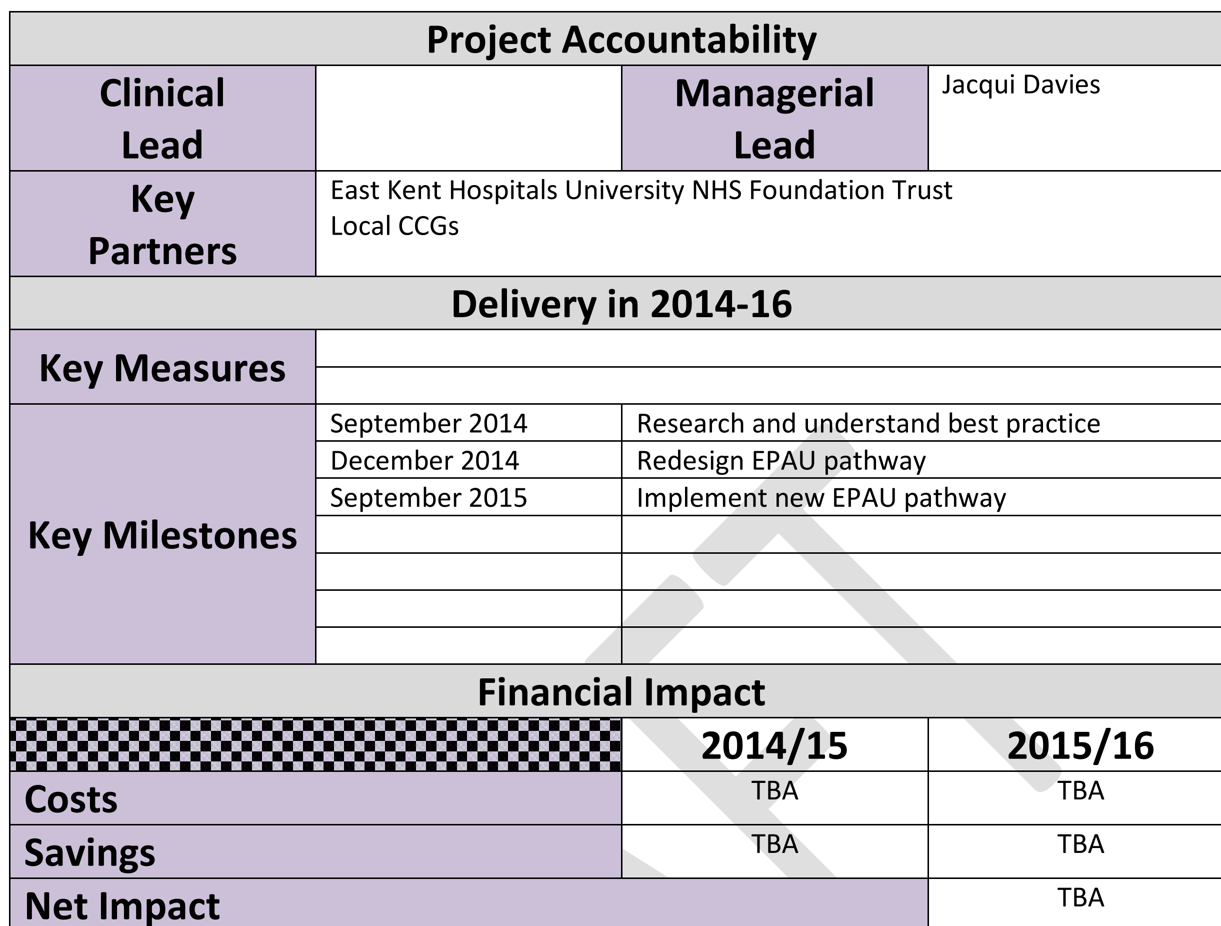

Project Accountability			
Clinical Lead		**Managerial Lead**	Jacqui Davies
Key Partners	East Kent Hospitals University NHS Foundation Trust Local CCGs		
Delivery in 2014-16			
Key Measures			
Key Milestones	September 2014	Research and understand best practice	
	December 2014	Redesign EPAU pathway	
	September 2015	Implement new EPAU pathway	
Financial Impact			
		2014/15	**2015/16**
Costs		TBA	TBA
Savings		TBA	TBA
Net Impact			TBA

DRAFT

Multi-agency whole system approach for supporting disabled children and young people with challenging behaviour	**Child Health and Maternity**

Description	Strategic Fit • Kent Health and Wellbeing Strategy Evidence Base • Department of Health's Report into Winterbourne View • Children and Families Bill • Kent Sufficiency Strategy (2013) Key Changes • A new multi-agency integrated pathway involving professionals working at universal, targeted, specialist and highly specialist levels Integrated assessments and care planning process aligned to the new Education Health and Care plans High Level Benefit Assessment • Children and young people are able to remain living at home with their families. • Children and young people are educated in a Kent school. • Children and young people are able to maintain or develop friendships and access local community services. • Families feel safe in their own home. • Families feel confident in managing their son or daughter's challenging behaviour and are able to participate in everyday activities. Key Risks • Delay in recruiting the right staff with the right level of training and experience. • Unable to agree contract variation to support the implementation of the transformation programme. • Decision by any partner not to invest in this transformation programme.

NHS Outcomes Framework

1	2	3	4	5
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from episodes of ill health or following injury**	**Ensuring that 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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Project Accountability			
Clinical Lead	Dr D Grice	**Managerial Lead**	Martin Cunnington
Key Partners	East Kent Hospitals University NHS Foundation Trust Kent County Council Sussex Partnership NHS Trust Local CCGs		

Delivery in 2014-16		
Key Measures		
Key Milestones	June 2014	Baseline data and scope of the evaluation agreed.
	September 2014	New outcome measures and KPIs included in a range of contracts and a central data collection system agreed.
	December 2014	Remodelling and training within CAMHS, social care and education to implement new integrated pathway across universal, targeted and specialist services

Financial Impact	2014/15	2015/16
Costs		
Savings		
Net Impact		

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