Meeting:	Ashford Health and Wellbeing Board
Date of Meeting:	
Agenda item:	
Subject:	Strategic Commissioning Plan
Reporting Officer:	Neil Fisher, Head of Strategy and Planning

Action Required: This paper is for:

Approval		**Decision**		**Discussion/ Assurance**	X	**Information**	

Paper (no more than 4 sides long):

The aim of our Commissioning Plan 2014-19, final version attached, is to explain how we will move from Joint Strategic Needs Assessment to delivering services that will drive improvements in health outcomes.

The CCG was required to submit a final plan to NHS England on 20th June, therefore this paper represents an opportunity to assure the Health and Wellbeing Board that the CCG fulfilled our responsibilities in this regard.

Before publication, significant public discussion has taken place which conforms with the CCG duty to ensure that individuals, to whom the services are being provided, are involved in the planning of services. Following final sign off, we have undertaken the following immediate steps:

- Press release for media
- Publish on CCG Website
- Update briefing for Health Overview and Scrutiny Committee, Kent Health and Wellbeing Board and Ashford Health and Wellbeing Board

Whilst this represents the final stage of the production on the initial five year plan, our efforts do not cease. We have now commenced refreshing the document to reflect the progress we have made to date, national policy changes which have come into force since April 2014 and recent announcements, such as Mental Health Access standards.

In December, we anticipate that NHS England will publish the NHS Mandate and planning guidance for 2015/16 which will set out the expectations of what we will deliver in 2015-16 and contain indications of changes between now and 2020.

Early indications include CCGs taking on a role in commissioning Primary care (GP) services and a focus on personal budgets for patients with long term needs. This is in addition to the Mental Health standards which we announced on 8th October.

Conflict of Interest? (if yes describe)	None					
Finance Assessment Completed?	**Yes**		**No**		**N/A**	**X**
Equality Impact Assessment Completed?	**Yes**		**No**		**N/A**	**X**
Strategic Objective link: **Risk Register links (reference number)**	If the Plan is not approved there significantly negative impact on the CCG's reputation and undermine the CCG's ability to meet NHS England's Quality Assurance process.					
The Health and Wellbeing Board are asked to: The Health and Wellbeing Board is being asked to note the current version of the SCP.						

Ashford Clinical Commissioning Group

Strategic Commissioning Plan

2014 - 2019


Sheppey Community Hospital
Swale
Thanet
Queen Victoria Memorial Hospital
Sittingbourne Memorial Hospital
Whitstable & Tankerton Hospital
Kent & Canterbury Hospital
St Martins Hospital
Faversham Cottage Hospital
Canterbury and Coastal
West Kent
Ashford
South Kent Coast
William Harvey Hospital

Contents

NHS Ashford CCG covers the town of Ashford as well as surrounding rural areas.

The CCG is made up of the 15 general practices (doctors' surgeries) in the Ashford area. The day-to-day work is overseen by a governing body, which is responsible to the GP practices for commissioning the right healthcare services for people in Ashford and ensuring they provide high quality, value for money care.

There are 6 GPs on the governing body, a chief nurse, registered nurse, hospital doctor, three lay and independent members with particular expertise in audit, patient engagement and strategy and planning as well as senior CCG managers. The governing body is supported by a number of sub-committees and working groups, including an Audit Committee. The full list of governing body representatives, senior management profiles, members of the Audit Committee and a statement setting out governance arrangements for the CCG are detailed in annexe one and two of this report.

Data Point	Data
Registered patient population:	122,000
Number of GP practices:	15
Neighbouring CCGs	4
Community Hospitals	0
Acute Hospital (within CCG boundaries)	1

The CCG has an annual budget of £133 million to deliver healthcare services for the 122,000 people registered with a GP surgeries in the Ashford area. That equates to around £1,095 per person.

The vast majority of the CCG budget was spent on care provided in a hospital setting, other services such as specialised care, the healthy child programme and primary care (GPs, Pharmacy and Optometrists) are paid for by NHS England. Kent County Council commissions public health services, such as sexual health, stop smoking and healthy weight programmes.

Our priorities for 2013/14 were developed in consultation with local residents and informed by Kent County Council's Joint Strategic Needs Assessment (JSNA), the local health and wellbeing strategy and national policy.

Each priority was led by a GP Clinical Lead and supported by a team of commissioning staff. Patient and public views were incorporated in both the setting of these priorities and as the work programme emerged which ensured that a patient and clinical perspective was at the core of every discussion and decision.

In line with the Kent Health and Wellbeing strategy, we also aimed to ensure:

- Every child has the best start in life
- People take greater responsibility for their own health
- The quality of life for those with long-term conditions is improved with quality care and support
- Those with mental ill health are supported to live well
- People with dementia are assessed and treated earlier

Our work also dovetailed with the NHS outcomes framework, which included:

- 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

Our priorities for 2013/2014 were:

1. Maintain the health status of the population
2. Reduce health inequalities across wards
3. Maintain clinical effectiveness
4. Dementia

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.

There is one main provider for adult mental health services across Kent and Medway (Kent and Medway Social Care Partnership Trust - KMPT) and the provision for children and adolescent mental health services (CAMHS) is through Sussex Partnership Trust. More generally the Young Healthy Minds programme, run by Kent County Council puts in place services and resources to support children's emotional wellbeing.

Mental health disorders take many different forms and affect people in different ways. Schizophrenia, depression and personality disorders are all types of mental health problem. 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.

"Live it Well" is a partnership between social care mental health commissioning (KCC and Medway Council) and NHS commissioning. Live it Well will change the emphasis of mental health services, redirecting some of the resources, away from secondary, statutory services which have traditionally decided on the service with service users as passive recipients; and instead commissioning services that are closer to, and responsive to, the needs of service users and carers, for instance in primary care.

The CAMHS service is tiered to provide assessment and treatment for children, young people and their families up to the age of 18, who are presenting with signs and symptoms of severe, complex and enduring mental illness.

What have we achieved

This period we have hosted a community event at which we have asked our local population to help identify the service gaps as well as provide suggestions on possible solutions and the priority they should be delivered in. In response to this work we have undertaken the following:

- Implemented a mental health crisis hot line for GPs to enable them to better support patients in their own care setting; and
- Improved access to psychological therapies by increasing the number of providers which has driven down the average waiting time for assessment and treatment to two weeks

In addition we also initiated a review of the mental health urgent care pathway; the aim of this work is to reduce patients being admitted to hospital through access to timely appropriate support. We expect the review to be completed in the summer 2014.

Health Help Now

In December 2013 NHS Ashford CCG launched Health Help Now - an innovative new service to help people in the Ashford area.

The Health Help Now web app can be found online at www.healthhelpnow-nhs.net and is free to everyone who lives and works in the area.

It functions like a mobile phone app and helps people check their symptoms and find the best place for treatment – showing which services near them are open. It breaks down symptoms by age – baby, child, teenager, adult and older adult. This is to make it easier for people to find the right treatment for them.

The app has been developed with input from local GPs, hospital doctors, paramedics and other health professionals

Health inequalities are defined as the "differences in health status or in the distribution of health determinants between different population groups" Those differences are inequitable when they can be determined as being unfair or avoidable.

Social determinants of health are a collective set of conditions in which people are born, grow-up, live and work. The World Health Organisation notes that in turn these conditions are shaped by a powerful over riding set of forces: economics, social policies and politics.

Our influence on many of these factors is limited but we are able to ensure that any services we commission are offered and delivered equitably. One of the ways we have achieved this is by reviewing our existing services offered from primary care to ensure they are offered on an Ashford wide basis rather than individual practice based:

- Gynecological service – We implemented an additional consultant led community based clinic at Wye as our review found that community provision did not cover patients in that locality. This has reduced the need for patients to travel to hospital and has reduced the length of time patients wait for assessment.

- We have been involved in a national project run by KCC which supports "troubled families" to address health needs of their entire family. For the CCG this means targeting services and liaising with respective GPs on areas such as health assessments, childhood vaccinations and immunisation and access to appropriate psychology services if required).

The principle behind maintaining clinical effectiveness is to ensuring that all care given by the NHS is safe, evidence based, cost effective and delivers consistent high quality outcomes.

In our first full year we have attempted to review all the services commissioned by the CCG to ensure they meet and where possible exceed the above aspirations. On areas where we felt this was not the case we worked collaboratively with the providers to support them to achieve the high standard we and our population.

For example, Joint injections (non-back related) were provided by a number of providers each with slightly differing criteria for treatment and each using different approaches. This resulted in service inconsistencies across Ashford and increased hospital visits for patients. To combat this we agreed standard clinical criteria and standardised treatment procedures, in addition we implemented a primary care delivered service which reduced the need to attend hospital ensuring the appropriate treatment at point of assessment.

During this period we have implemented the NHS England Risk Stratification approach and tool. This is a decision-making approach used to identify those patients at risk of admission to hospital. The approach brings together teams from a variety of agencies, including health and social care, so that we can offer earlier intervention to help patients to improve the management of their condition.

Carpal Tunnel Syndrome

Carpal Tunnel Syndrome has a national prevalence in primary care, around 1.8% of population. It is caused by compression of the median nerve as it travels though the restricted space between the wrist bones.

There are a number of common treatments offered for Carpal Tunnel Syndrome. Night time wrist splinting keeps the wrist straight, and relieves symptoms for approximately 30% of patients. Previously splints were available for the patient to buy themselves or given as part of an outpatient attendance at hospital.

To avoid an unnecessary referral to hospital, we have now made it possible for GPs to give splints (provided by the CCG) to patients as a first line treatment. As this is a remedy for many people, hospital referrals have reduced and patients do not have to attend the hospital.

Community Geriatrician

In June 2013 we initiated our innovative geriatrician pilot project which offered support to care homes from a full-time consultant (known as a geriatrician) and a community matron working extended hours, who are the first point of contact for care homes when a resident's health deteriorates. They offered expert care to residents who became seriously unwell, without them needing to be taken to hospital.

The project, which is part of the Health Foundation's Safer Clinical Systems programme, was nationally recognised in September 2013 when it won a Health Service Journal (HSJ) Efficiency Award for community service redesign.

About 750,000 people in the UK have diagnosed dementia with approximately 689 of these people residing in the Ashford CCG area.

This number is expected to double over the next thirty years and this in turn will bring its own challenges to the way health services planned for. As a starting point we hosted a dementia event, which was attended by the general public, volunteers, care organisations and providers, to identify current service gaps as well as designing an action plan to address these.

The CCG is committed to improving the care and experience of people with dementia and their carers and the outputs from this work have been incorporated into our commissioning intensions for 2014/15 and our five year plan.

Starting with our GPs we have trialled a screening tool in three GP practices. The tool supports GPs to diagnose dementia. In addition KMPT have worked with GP practices to ensure their patient lists are complete for patients diagnosed with dementia, thus ensuring they receive the right support from appropriate services.

We recognise that carers of dementia sufferers are equally important and to support them in their role we have implemented a directory of services, accessed through their GP, which provides information on a wide range of services, including the voluntary sector services available to patients and their carers.

The CCG has joined KCC to implement the dementia friendly project, this project is attempting to ensure both local businesses and community groups have an improved understanding and awareness of dementia. Through increased awareness members of the public suffering with dementia will be supported to live independently and will not be subjected to stigma.

The NHS Constitution identifies a range of standards to which patients are entitled and which we are committed to deliver. We have set out our performance during 2013/14 against these standards below.

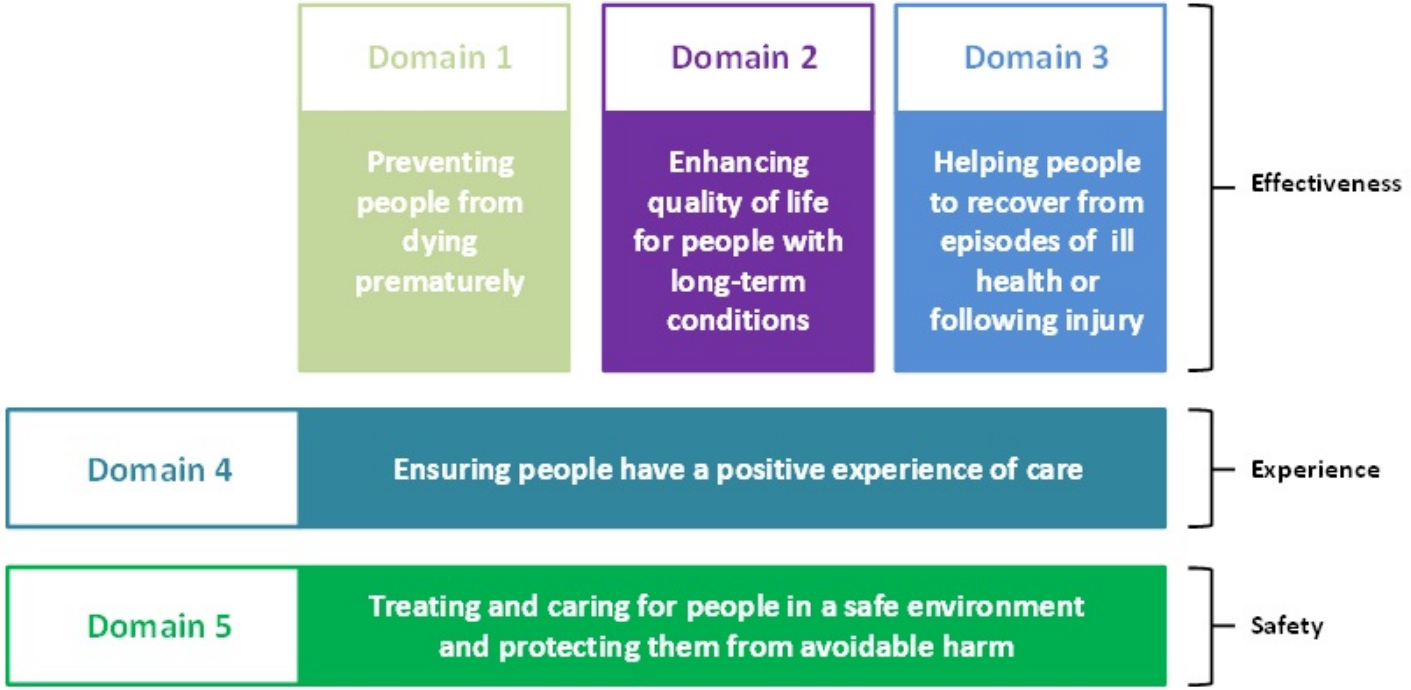
Referral To Treatment waiting times for non-urgent consultant-led treatment	Current Performance	Remedial Actions
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	91.70%	Achieving – No Additional Actions Required
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	98.00%	Achieving – No Additional Actions Required
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	94.30%	Achieving – No Additional Actions Required
Diagnostic test waiting times	**Current Performance**	**Remedial Actions**
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%	99.79%	Achieving – No Additional Actions Required
A&E waits	**Current Performance**	**Remedial Actions**
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%	94.77%	Underachieving – Investment through Winter Funding has brought recent improvement against this standard.
Cancer waits – 2 week wait	**Current Performance**	**Remedial Actions**
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%	95.59%	Achieving – No Additional Actions Required
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%	93.41%	Achieving – No Additional Actions Required

Cont…

Cancer waits – 31 days	Current Performance	Remedial Actions
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%	98.79%	Achieving – No Additional Actions Required
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%	97.17%	Achieving – No Additional Actions Required
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%	100.00%	Achieving – No Additional Actions Required
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%	100.00%	Achieving – No Additional Actions Required
Cancer waits – 62 days	**Current Performance**	**Remedial Actions**
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%	87.96	Achieving – No Additional Actions Required
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%	100%	Achieving – No Additional Actions Required
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	66.70%	Underachieving – With the work already completed and further plans for improvement, March is predicted to be compliant against this target
Category A ambulance calls	**Current Performance**	**Remedial Actions**
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)	75.95%	Achieving – No Additional Actions Required
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%	96.95%	Achieving – No Additional Actions Required

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.

Much of the basis for the government's mandate to NHS England is the NHS Outcomes Framework which describes five main categories of better outcomes demanded from local services. Our ambitions will always be focused on delivering the outcomes in these five domains:

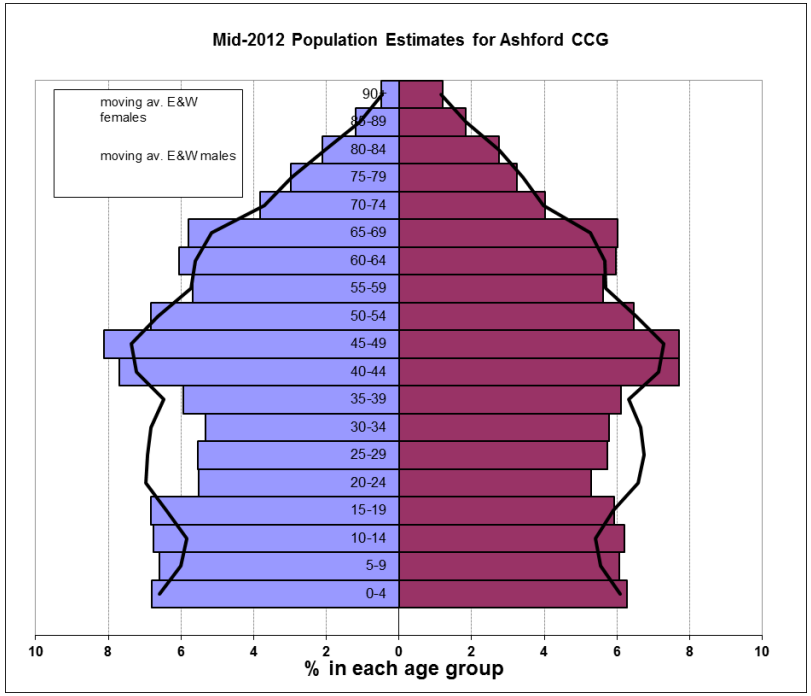


NHS England has translated these outcomes into specific measurable ambitions which against which we can track our progress. Here we explain how our plan meets the expectation of these ambitions

National Ambition	Our Vision
Securing additional years of life for the people of England with treatable mental and physical health conditions.	We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities.
Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	We will see practices working together in collaboration in support of Community Networks to offer wider variety of services, including social care and voluntary sector, with improved access for traditional GP services.
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	Through effective implementation of the Better Care Fund we will have primary and community care services working closer together, along with social care, voluntary organisations and other independent sector organisations.
Increasing the proportion of older people living independently at home following discharge from hospital.	To use the Better Care Fund as an opportunity to commission services together with other public sector partners. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we develop our Community Networks.
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	We will work with providers to put mechanisms in place to systematically gather real-time patient and carer feedback including ensuring the Friends and Family Test is in place across all providers
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.	We will ensure that vertical and horizontal integration of all services, through community networks which include health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	We will work with our providers and use the contractual levers available to ensure that patients are treated in a safe environment, with an emphasis on zero tolerance of avoidable harm and ensuring that nursing care is of the highest standard.

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.

Ashford's population is ageing due to lower birth rates and higher life expectancy over the past few decades. This is a universal problem that many developed countries currently face. The implications for health services are: increasing need for health and social care for elderly people at home or in care homes, requiring more staff and more funding.



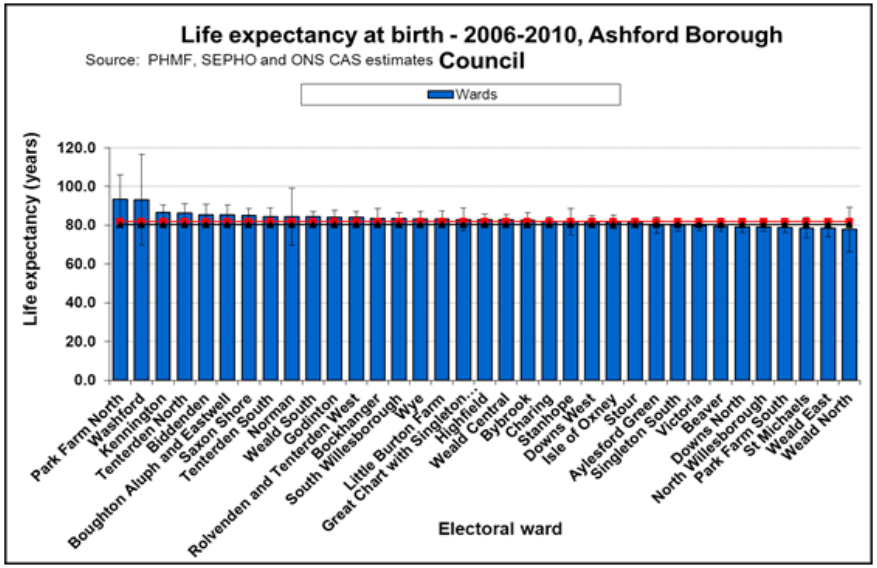
The distribution of the Ashford CCG population means that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the "ageing population time bomb". The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth.

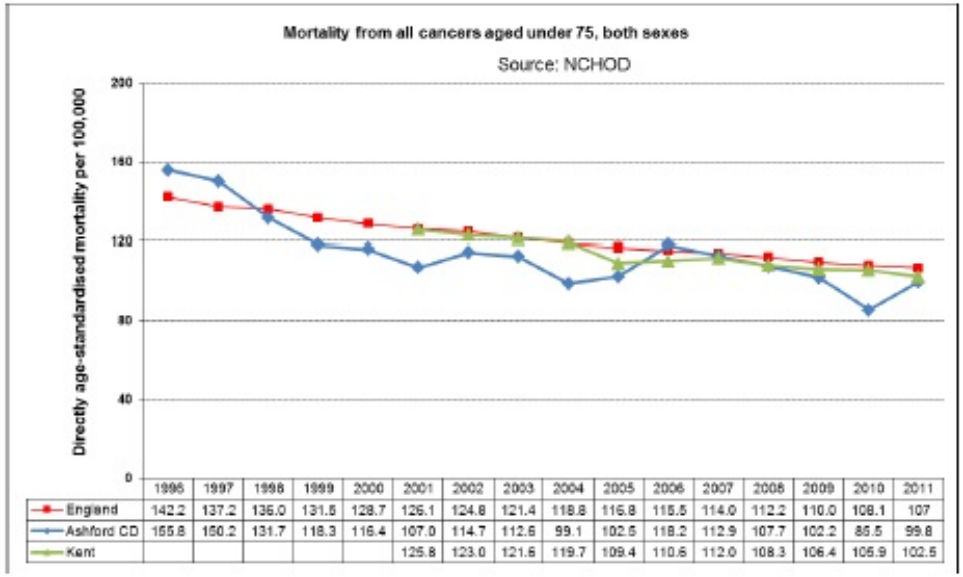
Life Expectancy	The average life expectancy in Ashford is 83.4 years for females compared to males at 80.7 The lowest life expectancy figures are in the wards of St Michaels and Weald East and Weald North, with the highest figures in Park Farm North and Washford. The difference in the number of years between the highest and lowest life expectancy at
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
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
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.
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.

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

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





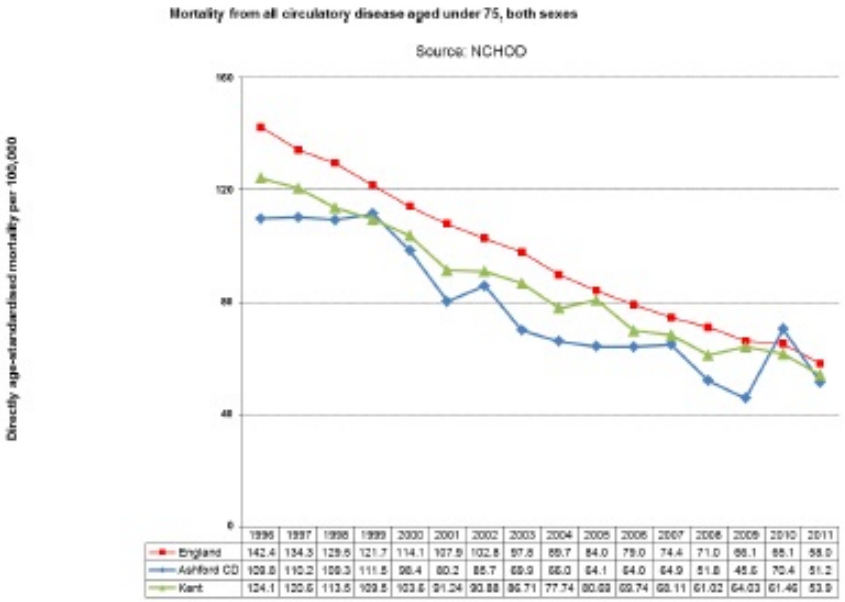
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
England	142.2	137.2	136.0	131.5	128.7	126.1	124.8	121.4	118.8	116.8	115.5	114.0	112.2	110.0	108.1	107
Ashford CD	155.8	150.2	131.7	118.3	116.4	107.0	114.7	112.6	99.1	102.5	118.2	112.9	107.7	102.2	86.5	99.8
Kent						125.8	123.0	121.6	119.7	109.4	110.6	112.0	108.3	106.4	105.9	102.5

Cancer

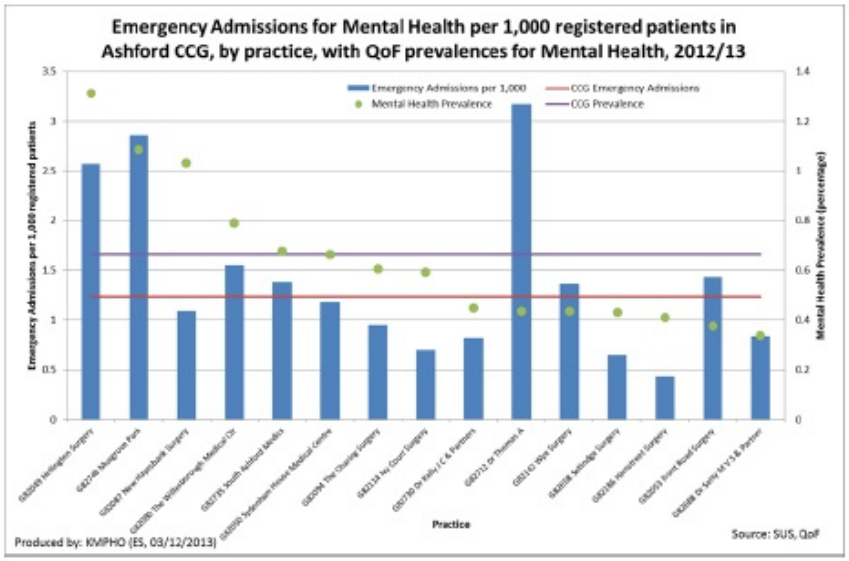
Mortality from cancer has decreased from 156/100,000 deaths in 1996 to 100/100,000 deaths in 2011. Again, a similar trend is observed for the whole of England.

Circulatory Disease

Death from circulatory disease has been decreasing steadily in Ashford from about 110/100,000 deaths in 1996 to 51/100,000 deaths in 2011. This trend is seen across England.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
England	142.4	134.3	128.5	121.7	114.1	107.9	102.8	97.8	89.7	84.0	79.0	74.4	71.0	66.1	65.1	58.0
Ashford CD	109.8	110.2	109.3	111.5	98.4	80.2	85.7	69.9	66.0	64.1	64.0	64.9	51.8	48.6	70.4	51.2
Kent	124.1	120.6	113.5	109.8	103.6	91.24	90.88	86.71	77.74	80.03	69.74	68.11	61.02	64.03	61.46	53.9



Mental Health

There is large variation in emergency admissions for mental health problems. The Ashford average lies around 1-1.5/1,000 registered patients.

The Kent Health and Wellbeing Strategy informs the NHS 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 come five key outcomes against which we will measure our success in improving the health of the people of Kent. These key outcomes are:

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). 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.

The Ashford Health and Wellbeing Board brings together the statutory and voluntary organisations which are involved locally 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.

Kent Integration Pioneers

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 .

In order to discharge its responsibilities, the board has identified three working groups to deliver against the domains of the Kent Health and Wellbeing Strategy

NHS Ashford CCG views engaging our patient and public as crucial to our role as commissioners of local health services. The experiences of patients and their families are extremely important to us because we know how their experiences are critical to both individual patients and their families and goes well beyond the health outcomes of care.

When we talk about making sure people have a good patient experience we mean doing more than just meeting their physical needs, we need to meet their emotional needs too by:

- Providing good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way
- Giving people information to make choices, to feel confident and to feel in control
- Talking to and listening to people as an equal; treating them with honesty, respect and dignity.

It is also important to involve people much more in their own healthcare and in shaping health services for the population as a whole. This is an on-going process, so we need continue to use opportunities that arise to get the views of our patients on our priorities and direction of travel. The population we serve – patients, carers, residents – should be free to hold us publicly to account directly or through elected representatives, Health Watch or overview and scrutiny committees

As the leaders of the local NHS, we want to build on and strengthen existing relationships, work with our patients and communities to inform decision making and planning and be an effective guardian and promoter of one of the country's most cherished brands – the NHS – at a time when the media and public spotlight in NHS services is brighter than ever.
In summary though, our main means of engaging patients and public include:

Means of Engaging Patients and Public	Detail
Stakeholder engagement events	We regularly hold partnership and stakeholder engagement events. These are usually well attended with representatives from organisations that reflect the needs of everyone in the community, thus ensuring quality and diversity is maintained.
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)	We aim to develop a Public Reference Group, with representatives from the PPGs as well as representatives from key voluntary 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 is an independent organisation set up to champion the views of patients and social care users across Kent. Their mission is to raise the public's voice to improve the quality of local health and social care services in Kent.
@AshfordHealth	Twitter account for Ashford CCG with latest news, tips and advice for Ashford's local community

"The NHS was set up to provide high quality care for patients, free at the point of need. The NHS has stayed true to this aim and to do so in the future, we must embrace new ways of working. The NHS, like every other healthcare provider in the world, is facing these challenges. Too often, the answers are to reduce the offer to patients or charge for services. That is not the ethos of the NHS and I am clear that our future must be about changing, not charging. To do so we must make bold, clinically-led changes to how NHS services are delivered over the next couple of years." – Sir David Nicholson, Chief Executive, NHS England 2013

In 2013, NHS England called on patients, the public and staff to join in a discussion about the future of the NHS, so would plan how best to deliver services, now and in the years ahead. This call to action set out the facts about future demands on NHS services, how the budget is currently spent and how services are delivered.

In line with our firm commitment to stakeholder engagement, we embarked on a process of engaging with practices, patients, carers, the public and other stakeholder groups in developing our commissioning priorities. These events focused on information giving, updating stakeholders on our role and activities, and information gathering, enabling us to interact with our 'Patient and Public' and 'organisational' stakeholder groups in a structured way to secure their input into this strategic commissioning plan.

Stakeholder Feedback	How are we addressing this?
Need to ensure that adequate resources are available in primary care so that long term conditions are managed	By putting General Practice at the centre of Community Network, we will invest in our practices to support them in becoming the gatekeepers of these community based services
Better outcomes achieved through improved integrated community services rather than patients being admitted to hospital Multi-disciplinary teams (an overarching team) working from a 'local' practice to look at all of the patients health needs, as quite often there are several conditions which need addressing in a patient with LTCs	We have already implemented the Neighbourhood Care Teams, which are an integration of existing health and social care support. Along with General Practice are using this approach as the foundation on which our Community Networks will be based.
The group discussed patient data being available to all agencies involved in their care (with the patients consent) so the patients' medical history is readily accessible. A single database detailing all aspects of patients' needs	One of the major issues faced in the development of Community Networks will be the independent IT systems. We are already working with a software manufacturer to develop a web-based tool which will pull information from a number of sources into a single database.
A better triage system is required to ensure that when there are issues regarding social care rather than clinical care, an adequate response is given i.e. issues around food, hygiene etc.	As part of our Cluster Teams we have a local referral unit. These individuals act as a single point of contact for clinicians, patients and their carers. This allows for triage to take place ensuring that the right care is offered by the right person, first time and avoids duplication and multiple visits.
"Mental Health Centres" across the community, to allow outpatient appointments and face-to-face contact – include ability for partnership working within the centres.	We recognise that patients have a number of complex needs and that mental health and long term poor health are interlinked.

Cont…

Stakeholder Feedback	How are we addressing this?
A public awareness campaign advising/educating patients regarding how they should be using emergency services and out of hours services.	We have a robust communication strategy highlighting the role of General Practice, Pharmacies, NHS111 and Minor Injury Services. However, communication is clearly not enough and so we have also taken steps to ensure that patients with urgent needs are seen by their GP on the same day, regardless of appointment availability. Additionally, we are integrating primary care (both in and out of hours) into our local Urgent Care Centres to ensure that patients receive the most appropriate level of care according to their clinical needs.
Patients should be managed/supported in the most appropriate setting for their individual case. Delivered as close to home as possible	Therefore, as we build on our Community Networks we will ensure that Mental Health services are front and centre of our approach. This will ensure that patients will be able to access services which support all of their needs and not just those associated with physical health.
In-reach services from Voluntary Sector to GP surgeries	We fully anticipate that the voluntary sector will have a crucial role as partners in the Community Networks. We fully appreciate that the voluntary sector provides high quality services for a vast range of needs.
Many ailments do not require secondary care appointments and should be treated in primary care. For example, post-operative follow up could be carried out in primary care	We are transforming the way in which patients access outpatient services. First through the introduction of Advice and Guidance services for GP so that they can continue to manage patient need themselves, but also through the introduction of “One-Stop” Clinics and earlier discharge from outpatient with advice and support for GPs.

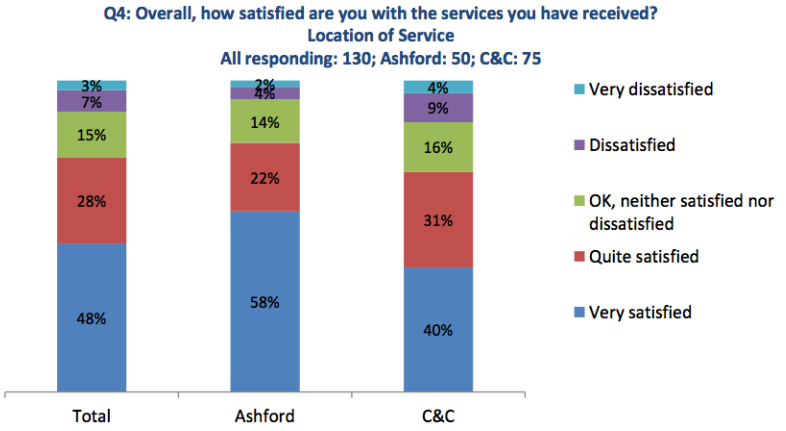
As part of gathering patient views, and in partnership with Canterbury and Coastal CCG, 153 people responded to our survey. They provided a variety of views but stated overall satisfaction with both the location and quality of community based services

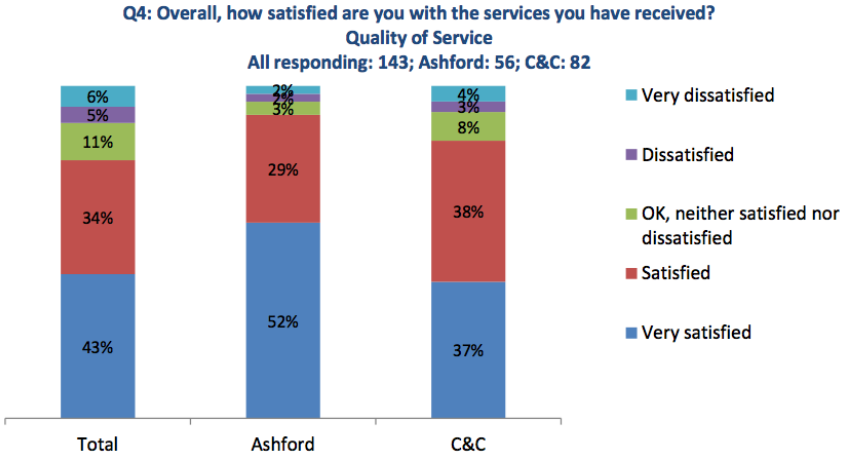
GP the key

- The most frequent point of contact for patients and carers.
- General good level of care.
- However issues in terms of time waiting for an appointment and telephone access.
- Time with the GP is too limited.

Location, Location, Location

- Generally positive
- However would like to see more services provided in a community setting
- More locally based day services for carers and patients





Care Planning

- Respondents not aware of care planning
- Low ratings for getting help at an early stage to avoid a crisis
- Not enough information about service availability
- Not enough information on choices regarding treatment and care

Communication

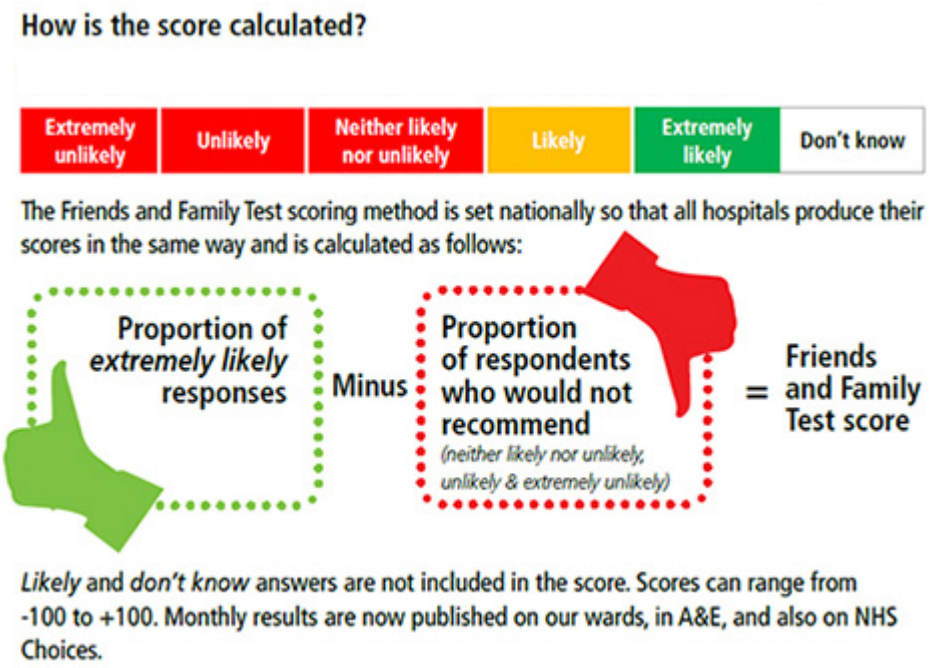
- Insufficient communication between healthcare professional and patients
- Communication between healthcare professionals not good enough and leading to delays in receiving appropriate treatment and care

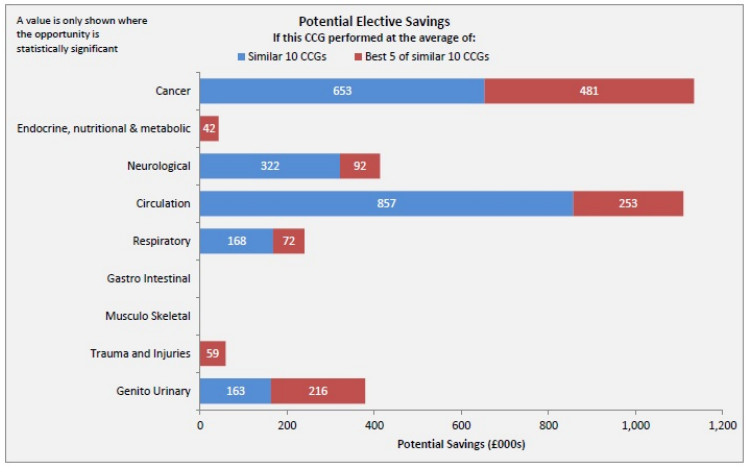
The Friends & Family Test

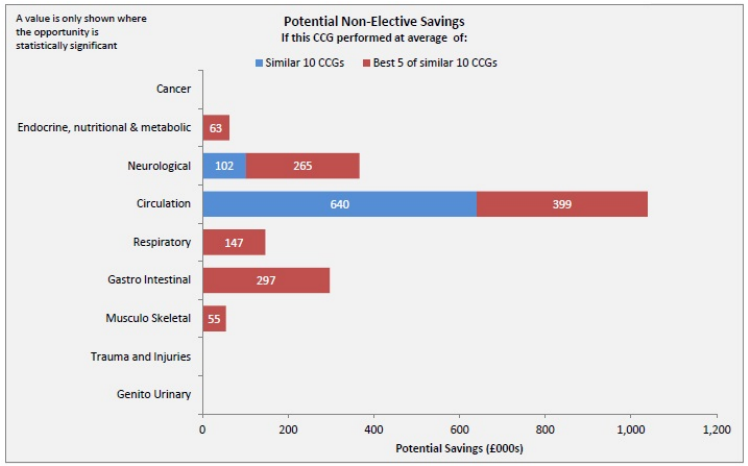
We will continue to use real-time feedback from our patients and carers and build on this to assess the experience of people who receive care and treatment from a range of providers in a coordinated care package across health and social care.

Feedback on patient experience is sought from a number of sources including Health Watch, Patient Participation groups; patient reference groups, health networks, and the family and friends test. NHS Ashford CCG will monitor providers' compliance with the Friends and Family test by:

- Scrutiny of data produced for the monthly Quality Report – National CQUINS
- Support and advise providers on methods to increase response rates for the FFT.







The CCG has identified a number of areas where there appears to be opportunities to increase value and improve outcomes. Some of these have been drawn from the Commissioning for Value packs that have been produced for each CCG by NHS England in association with Public Health England. The Commissioning for Value approach begins with a review of **indicative data** to highlight the top priorities (opportunities) for transformation and improvement.

These insights have been utilised to help inform and prioritise commissioning activities in the first phase of the strategic plan.

The data is drawn primarily from the 2011-12 financial year. Whilst some actions have been taken in the intervening period to address these areas, the CCG believes that a significant proportion of the financial opportunities remain in place.

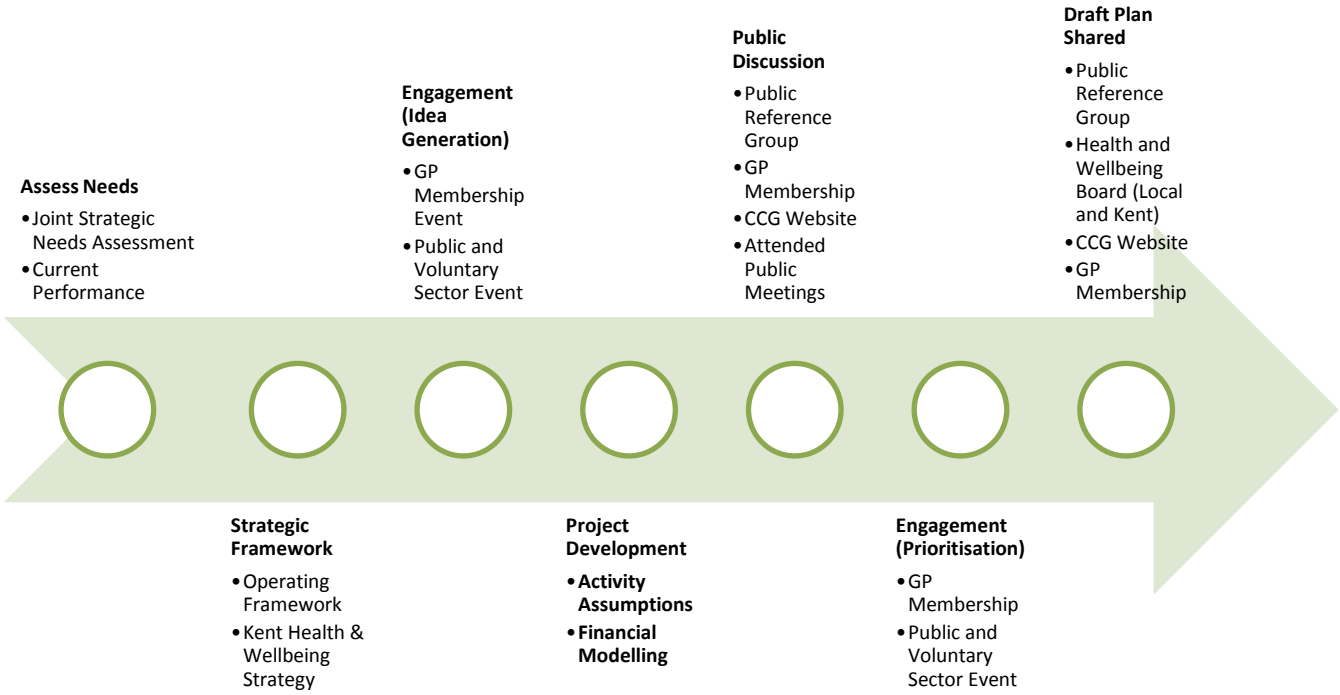
The programme areas that appear to offer the greatest opportunity in terms of financial savings are: Cancer, Circulation problems (CVD) and Neurological System Problems.

Having identified these opportunities, the next steps are to undertake a further detailed examination of the programmes/services and to secure cross organisational engagement of clinicians and managers to confirm the opportunity and to devise the measures to be taken.

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 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. The resulting priorities and the inputs are illustrated below.



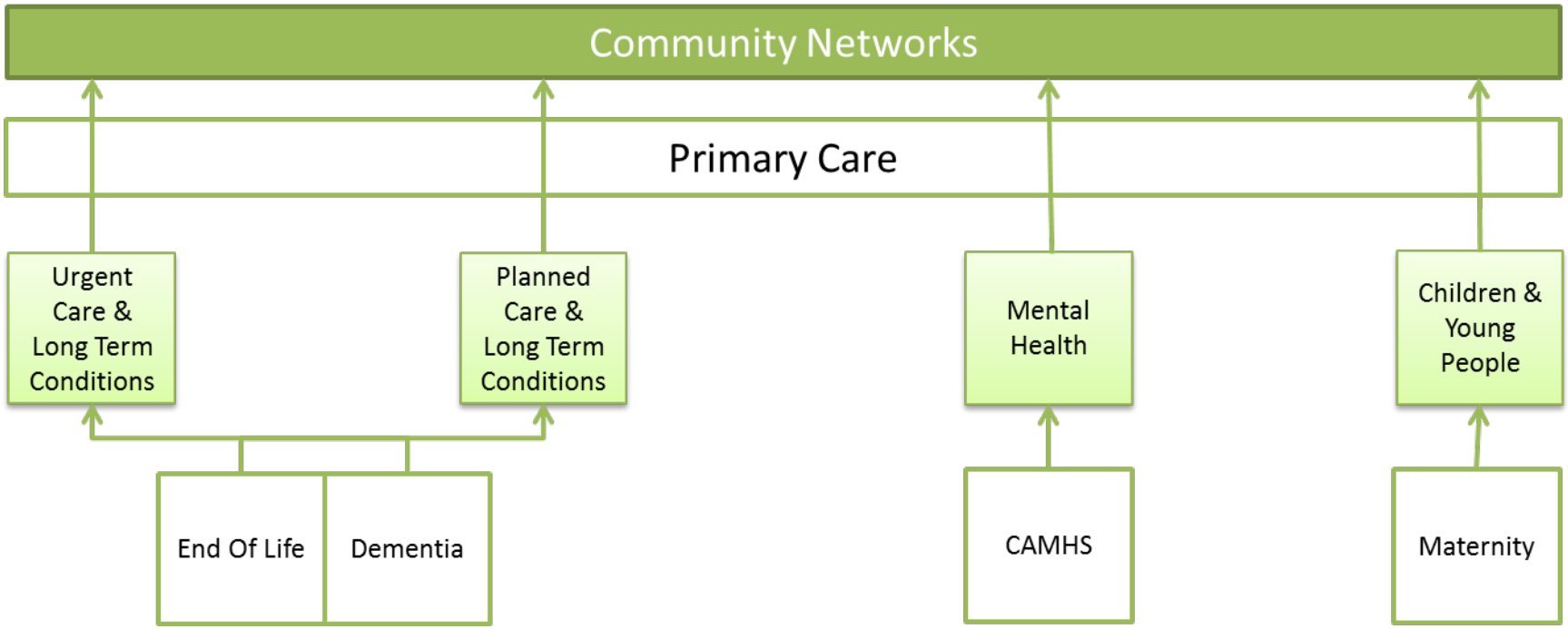
Priority Areas 2014-2019

1. Community Networks
2. Primary Care
3. Mental Health
4. Urgent Care/Long Term Conditions
5. Planned Care/Long Term Conditions
6. Children and Young People

The fundamental, underlying, principle of our five year vision is that care will be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a variety of locations within their local area –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals.

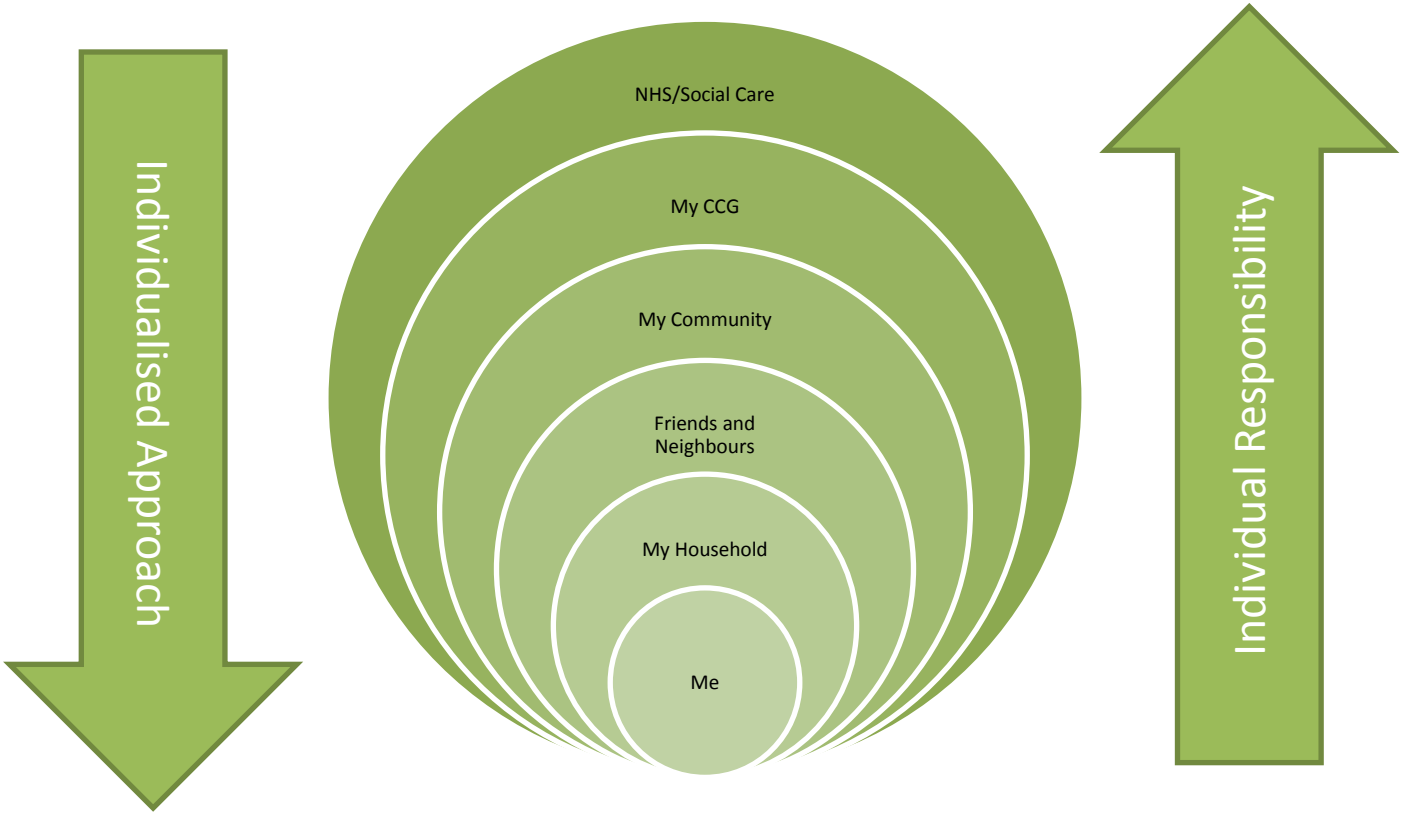
Our vision of community based networks will ensure the provision of healthcare services to enable patients, with a long term health issue or post an acute intervention, to live an independent life in the community or their homes. An essential element of this is closer integration of services provided out of hospital, available 24/7, and co-ordinated with specialist expertise in hospitals, among mental health providers and in related forms of care. Increasing attention needs to be given to care that is preventive and proactive with the aim of supporting people to remain independent for as long as possible and avoid the inappropriate use of hospitals and care homes.

In most cases, the community model would be led by GPs and would have freedom to deliver the outcomes required to meet the needs of their specific population. This would include the freedom to provide services directly or alternatively to arrange for them to be provided by others.



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 the local health economy and, by working with our members and partners, drive improvements in local services for patients.

Our patients and carers should be enabled to take ownership of their health and social care and with that accept responsibility for their health behaviour and use of health and social care services. They should expect a high quality, compassionate, safe and personal service based around their needs, present and future.



NHS Ashford CCG worked on our, vision and strategic priorities as we progressed through the authorisation process to become a statutory commissioning body and have continued to develop these further since April 2013.

The outcome is the result of consultation with our patients, members, partners and Governing Body. They are also aligned to and informed by both the Kent Health and Wellbeing Strategy and national strategic directions, as set out through "Everybody Counts"

Mission

"We strive to be 'a healthcare partnership' to be proud of and we are committed to improving the health and well-being of the population of Ashford."

Vision

"Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector."

Listen: We will listen to patients, be responsive and ensure their thoughts and needs shape the CCG's commissioning decisions. We will strive to ensure all patients have the best possible experience of the NHS.

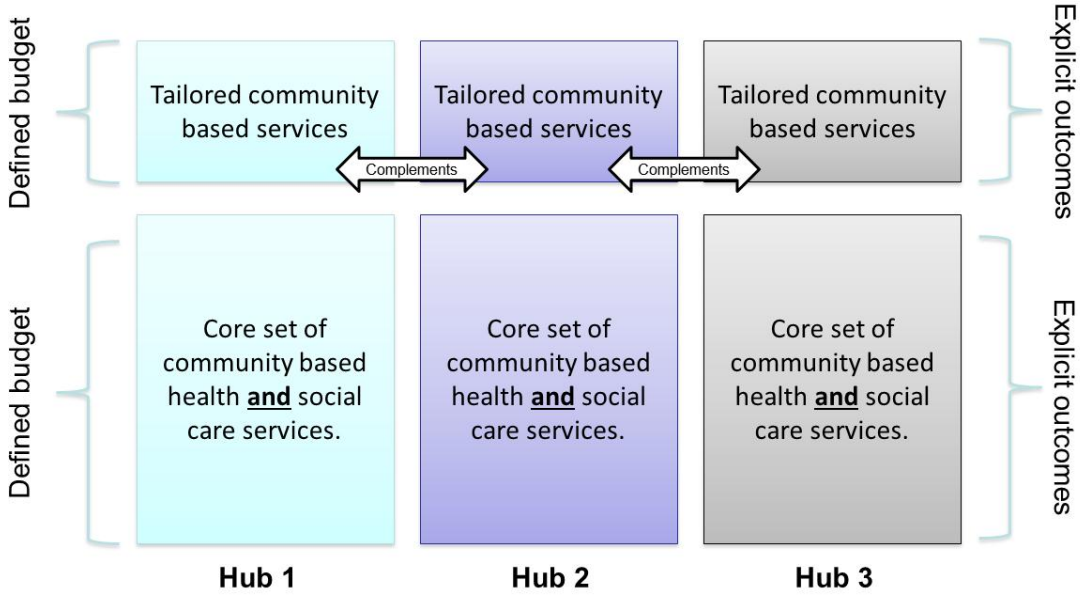
Collaborate: Best healthcare is delivered when working together – clinicians, patients, stakeholders and all sections of the community. We will work as one with our stakeholders within the area and partner with the other clinical commissioning groups in East Kent so that we become recognised as a confident organisation that listens, learns and delivers.

Be realistic about the challenge ahead: We know that with the increasing demands on services we need to deliver sustainable services that we can afford. We will be open and honest with all our patients and stakeholders and work closely with them to prioritise commissioning decisions.

Be open to change: As the needs of patients change and new treatments develop we will strive to make sure we always commission high-quality and value-for-money services.

We want our patients to recognise that the local NHS is sited within their own community and not around specific estate or hospitals. We want these networks to offer the largest possible range of services meeting the largest possible range of needs and that most aspects of any patient journey, through the health and social care system, is local to them.

One of the attractions of this approach would be to liberate local communities enabling them to innovate in how care is delivered in order to meet local need allowing scope for different approaches to be developed in different areas. For the public and patients, community networks have the potential to offer accessible and responsive services that extend well beyond what is currently available in general practices. These services would have general practice at their core, with practices working hand-in-hand with a range of other services that people need to access from time to time. GPs would help people navigate through these services and would retain a key role in co-ordinating care in different settings.



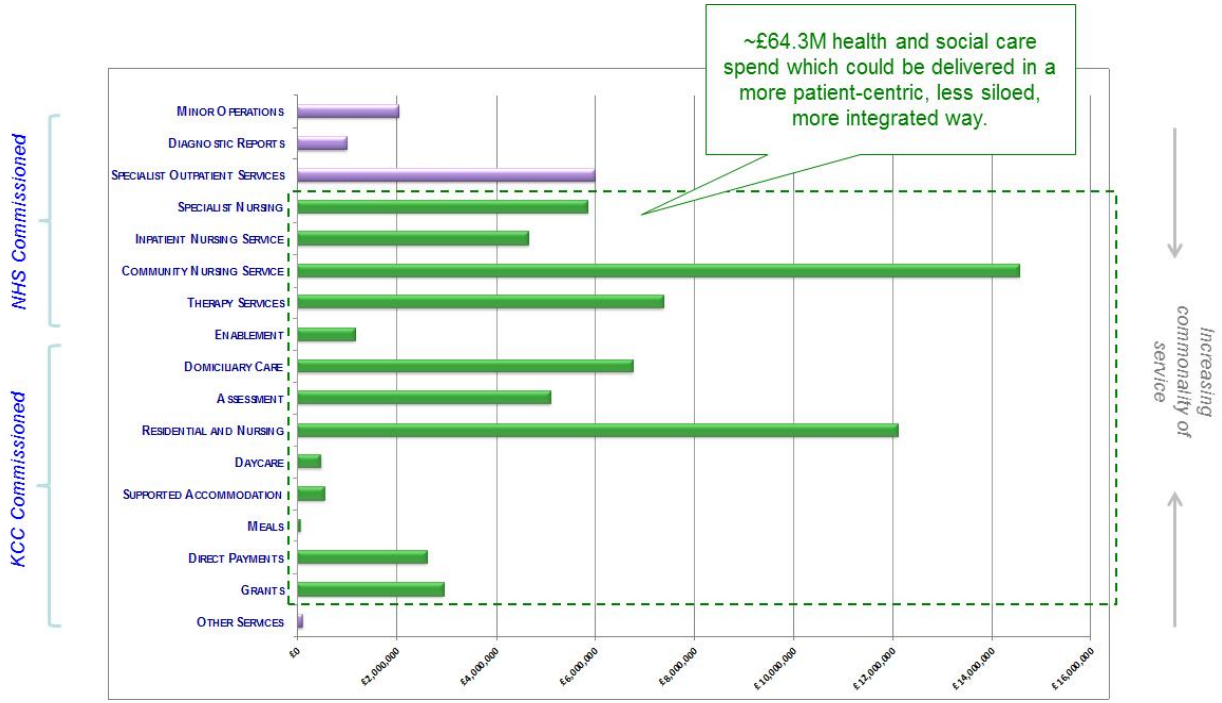
Example Services:

Tailored community based services **e.g. :**	Outpatients Specialist Diagnostics Addiction Services
Core community based health and social care services **e.g. :**	Assisted Living Befriending Care Homes Care Planning Carer Support Citizen's Advice Community Equipment Counselling Services Community Nursing Dementia Support End of Life Care General Practice Home Support Assessment Inpatient Beds (Step-Up and Step-Down) Meals-on-Wheels Minor Injuries Physiotherapy Pharmacy Respite Care Sexual Health

The development of community networks will require some services to change to support the aims and vision we want to achieve, others will need stability.

All of our local partners will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies within the whole system of care to ensure that the health and care system remains sustainable and of high quality.

Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we spend the taxpayers' funding wisely. The schemes we have identified in our plan are about applying targeted investment to transform the system and improve outcomes for citizens and the entire care economy.



Example figures. These figures include both NHS Ashford CCG, NHS Canterbury and Coastal CCG as well as Kent County Council Adult Social Services

Building on a long history of joint commissioning of services, the Better Care Fund provides further opportunity to commission services together. Through the two approaches, set out below, we will deliver the transformation of health and social care – delivering the 'right care, in the right place at the right time by the right person' to the individual and their carers that need it.

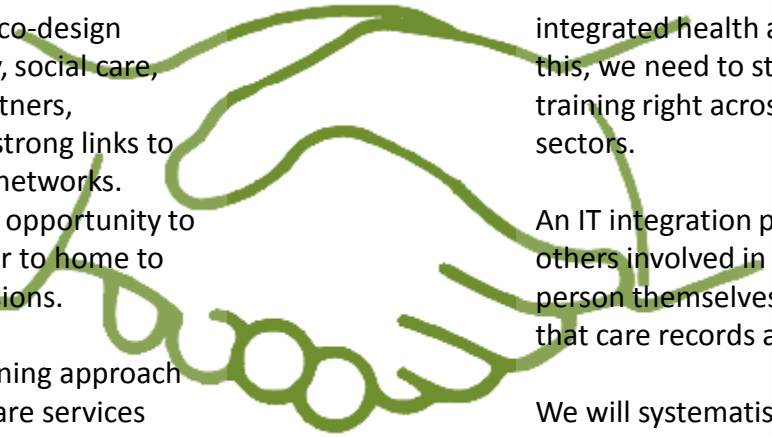
Integrated Commissioning

We will design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services by apply a proactive, rather than a reactive, model that means the avoidance of hospital and care home admissions.

We will introduce community based co-design partnerships between local authority, social care, patients, carers, voluntary sector partners, healthcare providers and CCGs with strong links to innovation, evaluation and research networks. These services will give people every opportunity to receive personalised care at, or closer to home to avoid hospital and care home admissions.

We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense, achieving the shift from spend and activity in acute and residential care to community services

New procurement models will be in place, such as alliance, lead provider, key strategic partner and industry contracts, delivering outcome based commissioned services incentivising providers to work together.



Integrated Provision

A model of 24/7 community based care, with fully integrated multi-disciplinary teams across acute and community services with primary care playing a key co-ordination role. The community, primary & secondary care interfaces will become integrated.

We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across health, social care and voluntary sectors.

An IT integration platform will enable clinicians and others involved in someone's care, including the person themselves, to view and input information so that care records are joined up and seamless.

We will systematise self care/self-management through assistive technologies, care navigation, the development of Dementia Friendly Communities and other support provided by the voluntary sector.

By 2015

- Co-production of Community Networks will have commenced
- First Community Network established
- Cluster Teams established ensuring links with acute, mental health, end of life care, pharmacy, voluntary sector and other specialist input as appropriate. Teams working 7 days a week, in local communities.
- Reduced admissions to acute care, having worked in a planned and phased approach, working with the population identified by risk stratification.

By 2016:

- Two Community Networks established
- Patients will have access to a shared care plan so that they and their carers know about their care and local support, enabling then to life independent lives.
- Access services through a local referral unit with access to crisis teams and rapid response
- Patients with LTCs further down the risk pyramid are fully engaged in self care schemes and may also consider purchasing technology solutions for themselves

Within 5 years:

- All Community Networks fully established
- A fundamental change in how the health and social care system operates, but also in how practitioners operate within this and how workforce planning needs to accommodate integration.
- Reduced length of stay through integrated working in the A&E department to enable improved treatment for patients and support them to return home with effective health and social care support.
- Everyone coming through an MDT has an integrated anticipatory care plan – this plan not only identifies someone's needs should they go in to crisis but also supports self-care and contingency planning.
- Telemedicine and interactive technology used to reduce the need for patient to be in same physical space as carer or clinician before clinical care can take place.
- Through our digital engagement strategy, we will see a vast number of people in our communities benefiting from connected care using readily available technologies.

Our Vision:
We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.

General practice is widely recognised to be the foundation on which NHS care is based, Ashford is no different. General practice has a central role within our vision for the next five years, providing care alongside other NHS staff working in the community, voluntary sector organisations and colleagues in social care.

Whilst NHS England have responsibility for commissioning GP services through the national GMS and PMS contracts, general practice delivers significantly more services than ten years ago and this trend will continue with a proportion of this additional work transferred from traditional community or hospital bases.
In order for this is be possible a number of changes in the way which general practice operates will need to occur.

This may require moving away from the current model of small, independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the networks of care that are required

Ultimately we anticipate that the outcome of this longer term approach will mean larger or federated practices offering more services, including Social Care, acting as the central hub for a wider variety of services and with improved access for traditional GP services.

By 2015:
- More patients will be managed in primary care with referrals only made when either access to more detailed diagnostics is needed or patients require specialist assessment.

By 2016:
- CCG commence Co-Commissioning of General Practice alongside NHS England
- Increased emphasis to be on General Practice seeing patients requiring home visits as early as possible in the day.
- Trial of roving GP scheme for home visits, reducing impact on individual GP practices.

Within Five Years:
- Individual practices, or groups of practices working together, delivering traditional GP services seven days per week

By 2015:

- Introduction of the Integrated Urgent Care Centres (IUCC)across each of our local acute hospital sites.
- Increase capacity in the Pulmonary Rehabilitation Service supporting patient self-management exercise groups

By 2016:

- New contract in place for GP "out of hours" services in April 2016 integrated with IUCC
- Falls pathway in place, linked to community networks, reducing the levels health and social care interventions required as a consequence of falls.
- Patients will have access to a shared care plan so that they and their carers know about their care and local support, enabling then to life independent lives.

Within Five Years:

- Community Networks providing high quality alternatives to urgent care services
- Reduction in emergency bed capacity and excessive periods of additional escalation beds.

Our Vision:
We want care that crosses the boundaries between primary, community, hospital and social care.

People using services and their 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. Furthermore, 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.

Traditional models of Urgent Care services have often been described as being highly fragmented and generate confusion among patients about how and when to access care.

The proposed model, working alongside the community networks, will bring services together to ensure that care will achieve a number of goals including a rapid multi-disciplinary assessment with 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 prevent a significant cohort of patients from having to attend hospital, improve recovery following an event and ensure that patients retain independence.

Our Vision:
We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

Our approach to the management of patients with long term health and social needs also links with our vision for urgent care and our community based approach. The number of patients with long term needs is expected to rise due to an ageing population and certain lifestyle choices that people make.

We will continue our current approach of identifying patients requiring additional support through risk profiling. Risk stratification tools are utilised to support the identification of patients at risk and GPs are working locally with community nurses and members of the integrated health and social care teams (locally referred to as Neighbourhood Care Teams) to ensure Management Care Plans are developed to support and educate patients to manage their own conditions.

The expenditure on dementia care is expected to rise as the expected prevalence for dementia is estimated to be higher than the recorded prevalence. In response to the National Dementia Strategy in Kent, action plans have been put in place to deliver high quality services for people with dementia to ensure that 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.

In addition improved access to community support, including supported housing options and dementia friendly communities, will lead to patients being able to stay within their own communities for longer.

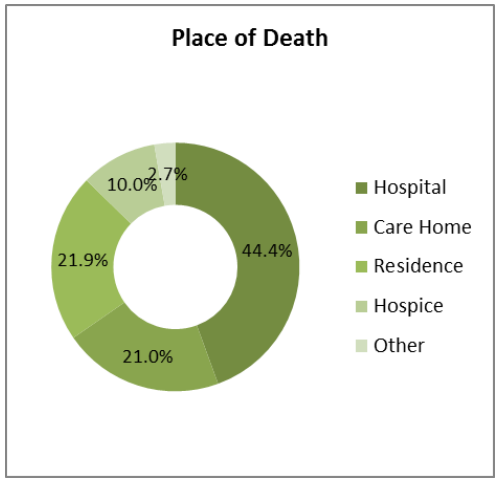
By 2015:
- Implementation of new outpatients model, following completion of 2013/14 public consultation .
- Increased rate of dementia diagnosis ensuring that patients and their families can access support at the appropriate time, improving their quality of life.

By 2016:
- Completed roll-out of “One-Stop Clinics” ensuring delivery of care in the right place, at the right time by the right clinicians
- Lead provider delivering evidence-based, outcome-based and innovative MSK Pathways
- Reduced fragmentation in cardiology pathways leading to improved health outcomes through earlier diagnosis and treatment of common cardiology and reducing the number of referrals and admissions.

Within Five Years:
- Telemedicine and interactive technology used to reduce the need for patient to be in same physical space as carer or clinician before clinical care can take place.
- Improved overall patient experience of planned care services

Dying is an inevitable event. That said, the process of dying, a phase often referred to as "the end of life" can be puzzling and frightening to patients, their family and their carers. It can be hard to know what to expect, how to get help and to know that the help is right for you and your family. All care decisions must come from a shared partnership between the health and social care professional alongside the individual, family and carer. For those who do not have capacity for their choices, or may lose that capacity in the future it is important that the right choices are made as early as possible. Too often, the final stages of life are treated as an emergency as demonstrated by a National Audit Office report which highlighted that up to 40% of the people dying in hospital had no medical need which would benefit from further treatment.

Despite preferences that suggest otherwise, the acute hospital remains the most frequent place of death (44%) for the Ashford residents who die annually. This proportion has been steadily reducing but the disparity between preferences of place of death and the reality remains stark. Early identification of individual wishes is the most important factor in maximising the chance for patients and health professionals to plan adequately and ensure needs and preferences of individuals are met.



When diagnosed with a terminal illness, or entering the last stages of their life; patients, carers and their families will be offered the opportunity to discuss the type of care the individual would like to receive, and where they would like to be treated. Families will also be supported to have conversations regarding where they would like to die and what is important to them in the last days of their life such as discussions about pain relief, family issues, and spiritual guidance, for example.

Key outcomes:

- Reduction by 15% in the number of people at the end of their lives being inappropriately admitted as emergencies to hospital by April 2016;
- Reduction in the number of patients dying in hospital by 15% by April 2016;
- Increase by 15% in the number of patients dying in their normal place of residence by April 2016;
- Reduction by 15% in care home admissions for patients who are at the end of their life and who can be appropriately supported in their own home environment by April 2016

Improving the mental health and wellbeing of our population is a priority for the CCG. Parity of esteem is defined as making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don’t suffer inequalities, either because of the mental health problem itself or because they then don’t get the best care for their physical health problems.

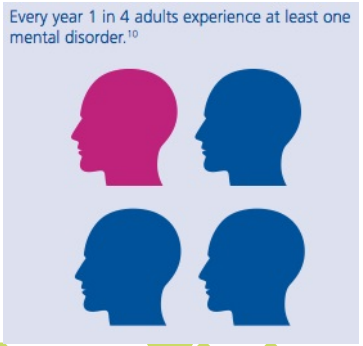
These deficiencies cannot be redressed solely - or even primarily - through greater investment, although it is crucial that mental health attracts greater priority in allocation decisions. Achieving parity between mental health and physical illness will require a fundamental change to the culture of healthcare, and in the way services are commissioned and provided.

The NHS needs to change fundamentally to meet the challenges of the future. Putting mental health on a par with physical health is an ambition that would transform the health service, enabling it to address the widespread prevalence of mental health disorders and the unacceptable inequalities experienced by those with mental illness.

50% of all people suffering with mental health issues experienced their first episode before the age of 14. By investing in early intervention and health promotion schemes for people with mental disorders the NHS can realise cost savings even in the short term.

“Crisis can happen at any time - two o’clock in the morning, Christmas Day - and people need help when it happens. I don’t know what I would have done if crisis care hadn’t been available to me when I needed it. You wouldn’t say to somebody with a broken leg or a heart attack that they have to wait to see a doctor during office hours. It should be exactly the same with mental health.

We really need to close this gap and start seeing mental health as important, and in need of the same amount of care, thought and urgency, as physical health.”



By 2015:

- Integrated all-age pathway for ADHD, reducing need to transition across paediatric and adult services
- All age Eating Disorders improving 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

By 2016:

- Increased community based service provision with shared care between GPs and specialist services
- Everyone coming through an MDT has an integrated anticipatory care plan – this plan not only identifies someone's needs should they go in to crisis but also supports self-care and contingency planning.

Within Five Years:

- Improved collaborative commissioning arrangements, working with partners across health and social care which reduce health inequalities and achieve better outcomes for those with, and others working with, mental health and well-being services.
- Improved innovation in community based services that support individuals in managing their mental health problems without the need to be admitted to an inpatient bed

Our Vision:
We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities

As with the CCG's underlying principle, wherever possible, services will be community-based and close to where people live, to this end we are already trialling a scheme of delivering care alongside GP practices

Alongside the successful increase in recovery rates for patients through the talking therapy projects, we will improve recovery rates for those with mental illness referred to secondary care and we improve the management. We are determined to improve the experience of those with enduring mental illness whether it is schizophrenia, bipolar or borderline personality disorder or whatever.

We have already invested in increasing the number of inpatients beds locally and will now turn our attention ensuring that crisis teams are being effective to prevent admissions and that the quality of in patient care is optimised and that efforts are made to admit patients as locally as possible. Additionally we will ensure that patients requiring urgent support are offer the same four-hour guarantee as those seeking urgent care service for physical conditions.

We will identify mental health services where integration in the long term is most likely to deliver sustained clinical and financial value. We will enhance good mental health and wellbeing as part of the community networks in order to reduce the number of people who get common mental health problems, and lessen the stigma and discrimination associated with mental ill-health. We will ensure that prevention is targeted at those at higher risk but also that the right services are there when people need them.

Our Vision:
We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation

As our health profile demonstrates, NHS Ashford CCG will see significant growth in the child population during the next 7 years; however some of the largest increases will fall within the 0-4 age range, creating significant demands on paediatric services.

The current system within NHS Ashford CCG area is disjointed and parent carers have also stated that it is confusing and difficult to navigate. There are a range of access points within the health system for children, young people and their families including GP practice, minor injuries, A&E, Short Stay Paediatric Assessment Unit and out of hours, community children's nursing service, health visiting service and school nursing service.

Through our community networks, we will ensure the integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation. This approach is supported by national research and best practice in relation to developing a whole system approach to improving emergency and urgent care for children, young people and their families.

We will align our paediatric transformation programme, and whole system approach for urgent and emergency care for children and young people, with the wider transformation programmes outlined above to maximise impact and promote effective transition to adult services.

By 2015:
- Established improved access and support in place for mothers in early stages of their pregnancy .

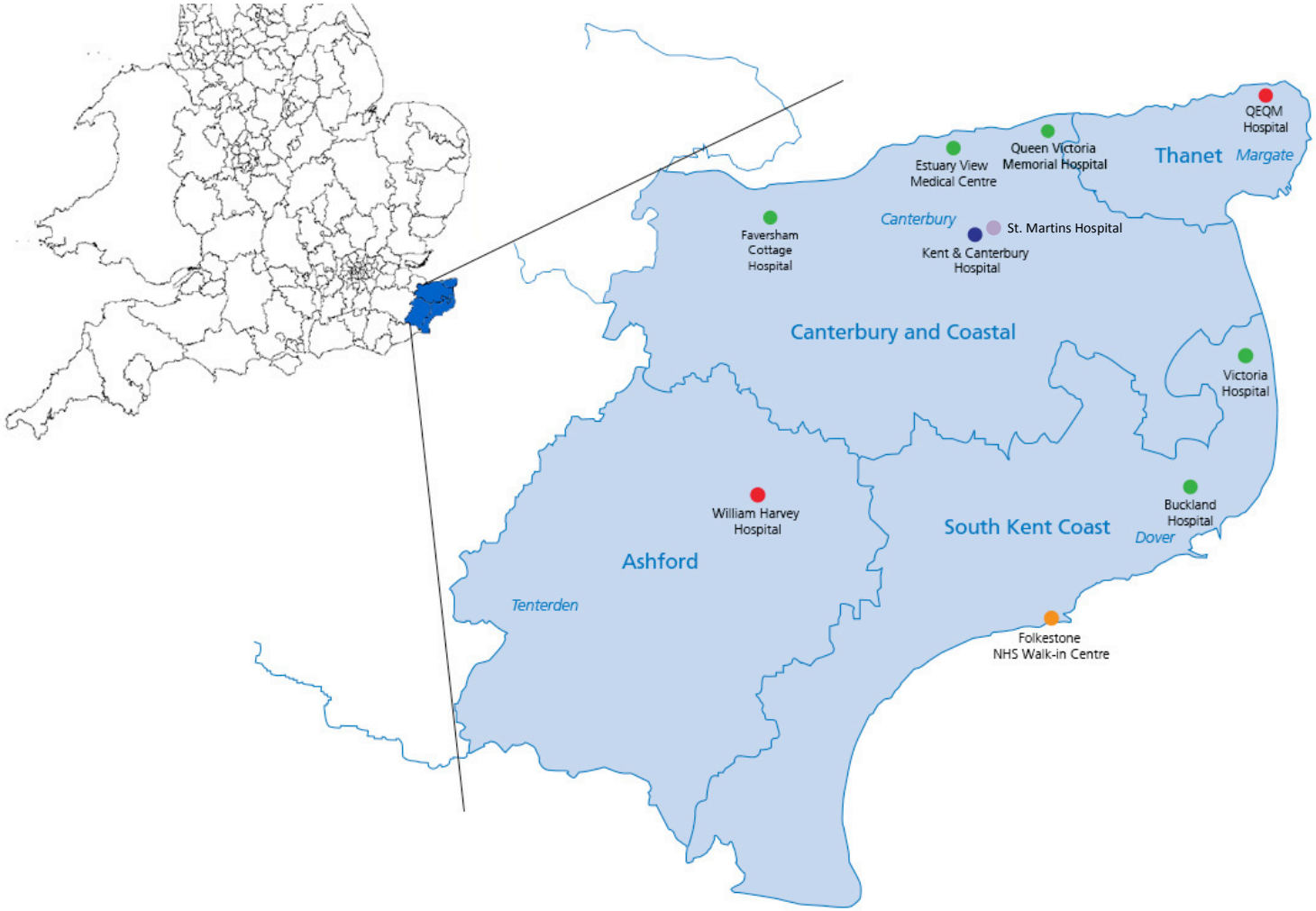
By 2016:
- Increased rates of initiation and sustained breastfeeding
- We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels.
- Ante natal and post natal maternity pathway improvements.

Within Five Years:
- Community Networks will ensure that children and young people with complex health needs are able to receive high quality, locally accessible community based support.
- All disabled children and young people, those with special educational needs are met through their individual Education, Health and Care Plan
- Parents and children are able to exercise greater choice and control through the use of a personal budget.
- Looked After Children receive high quality integrated care and are enabled to progress through the adoption system in a timely manner.

NHS Ashford CCG commissions services from a wide range of providers with provision well distributed across the patch. Quality and performance are good but not consistent across all providers. There is an increasingly diverse provider market but the local geography and poor transport links can limit the willingness and ability of people to travel to receive care.

NHS Domain	What services does this cover?	Who are our main providers?
Primary care	Predominantly traditional general practice services, however a number of GP practices offer a wide range of additional services including Minor Injuries, Ophthalmology, ENT, Cardiology and Minor Surgery	Our 15 GP Practices
Secondary Care (Acute)	Secondary (or 'acute') care is the healthcare that people receive in hospital. It may be unplanned emergency care or surgery, or planned specialist medical care or surgery	East Kent Hospitals University Foundation NHS Trust
Emergency Response	Ambulance trusts in England run the services that respond to emergency (999) calls for healthcare. These services are equipped to provide treatment at the scene of an accident. One ambulance service provider covers the whole of Kent, Sussex and Surrey.	South East Coast Ambulance NHS Trust
GP Out-of-Hours	Outside normal surgery hours patients may require a service normally offered by their GP, in this instance they are usually directed to an out-of-hours service. The out-of-hours period is from 6.30pm to 8.00am on weekdays and all day at weekends and on bank holidays.	IC24
NHS111	NHS 111 is available 24 hours a day, seven days a week. It can provide medical advice and details of the best local service that can provide care.	SECAMB in conjunction with Harmoni
Acute Mental Health Services	Unlike primary care services, which usually treat milder mental health problems, England's mental health trusts provide specialist care for people with more severe problems such as: severe and disabling anxiety, depression, obsessive compulsive disorder, schizophrenia, bipolar disorder, psychosis etc. Patients may also present a high risk to themselves, such as self harm or suicidal thoughts.	Kent and Medway NHS and Social Care Partnership Trust
CAMHS (Tier 1-3)	Tier 1: consists of non specialist services, for instance, common problems of childhood such as sleeping difficulties or feeding problems. Tier 2: consists of specialised support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services. Tier 3: consist of specialist multi disciplinary teams for more complex issues such as development problems, autism, hyperactivity, depression, early onset psychosis	Sussex Partnership Trust
Community healthcare	Wide-ranging NHS care for people, in their community, in a range of settings including people's own homes, nursing homes, health clinics, community hospitals. Services include, specialist diabetes services, cardia rehabilitation, continence support and advice, Epilepsy Specialist Nursing Team, Sexual Health (including contraception, GUM and young people's services) and educational nutrition and dietetics sessions.	Kent Community Healthcare NHS Trust
Specialist services	Specialist services such as transplantation, HIV and AIDS treatment, paediatric neuro- surgery and specialist cancer care. Tier 4 CAMHS consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated	Guys and St Thomas' NHS Foundation Trust Kings College Hospital NHS Foundation Trust South London and Maudsley NHS Trust (CAMHS Tier 4) Royal Marsden University College London
Hospice Care	Patients can access a range of individual or group activities which aim to support them in all areas of daily living from managing symptoms and planning for future needs, developing new skills and interests and meeting others. This offers patients and carers the information and support they need to continue leading an active and independent life in the community for as long as possible.	Pilgrims Hospices
Other services	This covers a wide range of services, such as; • Drug and alcohol services. • Hearing aid services. • Support for carers. • Support services for patients suffering from long term conditions. • Physiotherapy services.	Predominantly smaller providers including the voluntary sector and General Practice

The four CCGs in East Kent serve a population of approximately 659,000, with a combined budget of £831m. Services are commissioned from a number of different sites, including 88 GP practices, the main sites though are detailed below:



On the basis of population growth and CCG allocated funding projections, the gap between available funds and expected health costs will be as follows

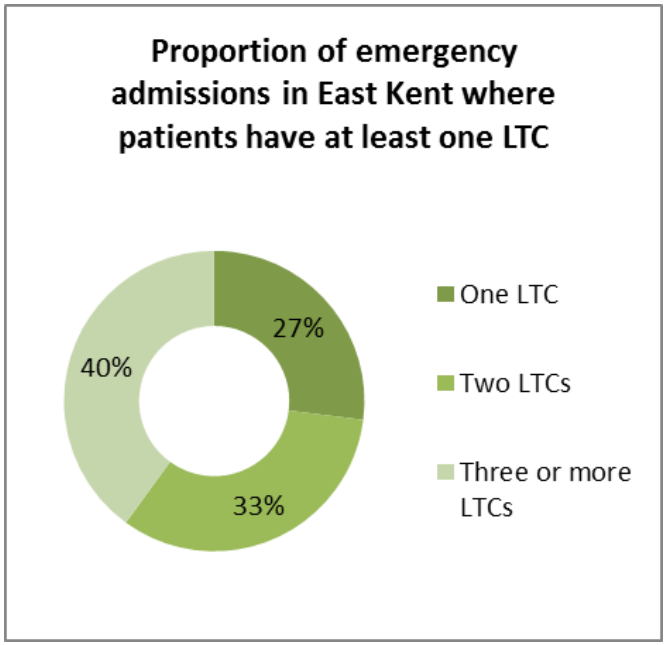
	2018/19 Gap (Budget Share)	2018/19 Gap (Demographic Forecast)
NHS Ashford CCG	£24 million	£27 million
NHS Canterbury & Costal CCG	£44 million	£49 million
NHS South Kent Coast CCG	£47 million	£52 million
NHS Thanet CCG	£35 million	£40 million
East Kent Total	£151 million	£168 million

Evidence indicates that in cases where patients have more than one Long Term Condition (LTC) the associated cost of treating their conditions is compounded by their co-morbidities.

Evidence from the Department of Health estimates that the average health and social care cost per person per year increases with number of LTC:

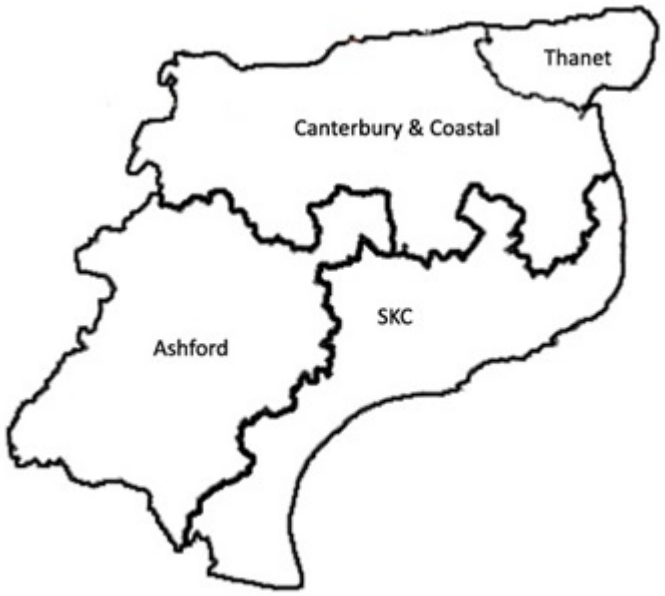
- no LTCs, average health and social care cost per person per year approx. £1,000;
- one LTC, average health and social care cost per person per year approx. £3,000;
- two LTCs, average health and social care cost per person per year approx. £6,000; and
- three or more LTCs, average health and social care cost per person per year approx. £7,700.

Furthermore, research outlines that 25% of over 60s have 2 or more LTCs. It is clearly important to consider the potential impact on cost of the health economy for the East Kent Planning Group of co-morbidities of LTCs.



Demographics:

- Older patients tend to have longer spells and are readmitted more frequently after a first hospital spell
- Based on recent trends, the proportion of the population requiring mental health services will increase, especially for people over 65
- The number of people with Long Term Conditions will increase with population growth
- Ageing is a fundamental factor, as the prevalence of LTCs is up to 6 times higher in over 65s than in under 65s
- Patients with LTCs have been recently estimated to account for 70% of the total health and care spend in England



A key element to the development of more joined up patient care will be effective communication between clinicians in different areas of the health system. The local governance arrangements have allowed our strategy and plans to be shaped through continued membership engagement and support.

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.

- Clinical Forum – Enables clinical discussion to explore areas where the four CCGs can work together in the development of strategy.
- Federation Forum and Whole System Board – Provides strategic oversight of the collaborative work across East Kent.

Part of our five year ambition is to ensure that we have specific, appropriate contracts that allow us to act fast on behalf of the patient when services do not meet the standards which our population expects and demands. Although contract management may be seen as operational rather than strategic – the impact it has had on our strategic outcomes means that this is a key enabler for us in delivering the outcomes set out in this Plan. As we move towards new contract mechanisms, whether alliance, lead provider, or Special Purpose Vehicle, we have laid the foundations for both risk and benefit sharing with our main providers, through the following contractual developments:

East Kent Hospitals University NHS Foundation Trust

Local arrangements are being negotiated that will embed (and assure) delivery of acute elements of the CCG's QIPP programme as well as incentivising the provider to go further by sharing some of the benefits. This approach will also reduce some of the risks inherent in the acute contract that has been in operation throughout 2013/14. Further changes to the plan are expected once the approach is agreed.

Kent Community Health NHS Trust

East Kent CCGs are moving away from the traditional block agreement towards a re-allocation based upon usage of community services. Whilst not ready for cost-per-case procurement, the re-based block better reflects the reality of service provision. This creates a cost pressure of £2.4m in 2014/15 (subject to change), although the effect is mitigated if considered across both Canterbury and Ashford CCGs.

Kent and Medway Partnership NHS Trust

Work is on-going to derive PBR based costs and tariffs for mental health services in Kent. Although not ready for live implementation, CCGs may agree a movement towards a fairer usage base in 2014/15. Currently a cost pressure of £0.9m is assumed for this change, although it may be revised when contract negotiations are concluded.

The View Across East Kent: Future Model of Provision

Primary Care
Whilst the 4 CCGs in East Kent have slightly different models for future primary care and community service delivery (community hubs; proactive care & universal teams) they share many common characteristics and all have the patient and GP at the centre.

The CCGs believe the ability to commission high quality primary care is a fundamental building block which enables delivery of their plans. As a consequence, there is strong interest in co-commissioning of primary care which ranges from as desire to commission jointly to wishing to explore the possibility of delegated commissioning responsibility.

Specialist Centres
East Kent CCGs vision is to commission services for those people who need treatment at specialist centres with the right facilities and expertise in order to maximise chances of survival and a good recovery, as close as possible to where they live.

In order to achieve this, discussions will be progresses across a Kent & Medway wide planning footprint as engagement with NHS England including specialised commissioning and Strategic Clinical Networks (SCN).

This will involve a strategic review of services, such stroke and vascular care, where a K&M or wider approach would benefit.

Additionally, we are keen to establish the repatriation of services which now lend themselves to more local delivery

Acute Care
Compared against peer groups both locally and nationally, our main acute provider performs favourably against a number of key metrics connected to operational activity and clinical outcomes.

However, a number of challenges will emerge over the longer term, and it is within this context that our main provider, East Kent Hospitals NHS University Foundation Trust (EKHUFT) commenced the development of an outline 5-10 year strategy 'Looking to Our Future', identifying key levers, drivers and their interrelationships, with a set of strategic options that illustrate the potential impact of those options on activity and the financial position of the organisation.

With the implications of our five year strategy, outline in this plan, it is clear that activity levels across the acute sector will reduce and therefore this will have an impact on how services are configured across EKHUFT's estate. Some of the activity reductions may create capacity for EKHUFT to respond to the CCG desire to repatriate services from London centres.

Part of the rationalisation has already commenced with a public consultation on the transformation of outpatient services. However it is clear that further developments will follow, specifically with regards high risk general elective and emergency (abdominal) surgery and the development of Integrated Urgent Care Centres outlined elsewhere in this plan.

Community Services

Kent Community Health NHS Trust (KCHT) are transforming their services so that they meet the future health and financial challenges. This programme of work, known as "The Human Touch", is will lead to an improvement of services in five major ways:

- Transforming models of care – to be more integrated and patient focused. Helping people to remain living at home at times of vulnerability, rather than see an unwanted, costly and unnecessary hospital admission.

- Transforming the times and places where care is provided – moving away from traditional health care settings to offer more services either within people's own homes or close by in friendly, community venues, making good health part of everyday life.

- Transforming the workforce - developing generic roles across directorates and functions, for example combining elements of the health care assistant role and the health trainer role to support the long-term conditions pathway.

- Transforming clinical support systems – offering better access for patients and more efficient ways of working for through technology.

- Transforming partnerships – alongside the CCG community networks, integrating health and social care teams, developing innovative joint solutions to support wider health and social care system transformation.

Mental Health

Kent and Medway NHS and Social Care Partnership Trust has embarked upon the implementation of a significant transformation programme which will support the delivery of excellence in all that the Trust does. This includes:

- **Improved recovery** through the implementation of community wellbeing centres and primary mental health care workers delivered in partnership with community networks thereby delivering a more seamless pathway of care and a more holistic approach to recovery.
- **Clinical Strategy** which aims to provide excellent community services close to home reducing the number of people who need inpatient care.
- **Organisational Development Strategy** which aims to ensure that we are not only an employer of choice but that we support the continued growth and development of all of our workforce to ensure that they have the skills to deliver excellence in all that they do.
- **Service User and Carer Engagement Strategy** which aims to ensure that we have a comprehensive range of approaches to engaging with service users and carers
- **Estates Strategy** which aims to ensure that all of our facilities provide a high quality therapeutic environment for service users and carers.
- **Information Communications and Technology [ICT] Strategy** which aims to promote the delivery of services through mobile technology.

Key Enabler: Contractual Management and Market Development

The CCG are keen to work in partnership with major providers to ensure that we can protect essential services for our local population. However, we expect to see a shift towards more integration between provider and an increase in health and social care community providers. Within that context we will develop a local market where there in only a plurality of providers where appropriate and where that doesn't undermine the underlying system vision of integrated services for our patients.

To facilitate a transformation in care, we will increase capacity in the community to manage a larger cohort of patients; embrace technology to support delivery of the urgent care strategy and enhance communication across Health and Social Care.

In any provider market we wish to develop an environment conducive to high quality training, for *all* providers, which ensures that our patients will receive the highest quality of care both clinically and non-clinically.

The CCG inherited many difficulties on being authorised regarding contracts and how contracts were managed together with a real difficulty in being able to set KPIs with our supporting services, as both organisations were only just starting. Many of these issues had an impact on the quality of services and outcomes for our patients – we have been able to address many of these during our first year.

Part of our five year ambition is to ensure that we have specific, appropriate contracts that allow us to act fast on behalf of the patient when services do not meet the standards which our population expects and demands. Although contract management may be seen as operational rather than strategic – the impact it has had on our strategic outcomes means that this is a key enabler for us in delivering the outcomes set out in this Plan.

A key area of patient concern and feedback related to our desire to integrate services and the consequent need for clinical information systems to talk to each other. Our patients were keen for us to identify a method which would ensure that whoever saw them had access to their relevant medical information, provided this was secure.

The MIG has been developed by providers of GP Systems and allows controlled real time access to some details in GP Record for other local providers;

1. **Summary** (including current problems, current medication, allergies, and recent tests)
2. **Problems view**
3. **Diagnosis view**
4. **Medication** (including current and past prescriptions, and issues)
5. **Risks and warnings**
6. **Procedures**
7. **Investigations**
8. **Examination** (blood pressure only)
9. **Events** (consisting of encounters, admissions and referrals)
10. **Patient demographics**

The MIG currently works with the GP systems currently in use across our GP practices and can work with the local GP Out-of-Hours service , our local hospitals and the “Share My Care” system.

Only clinicians with valid credentials from an organisation which has been given access, the GP practices, and with a valid reason to view a patient’s record will be able to access information. Even in this scenario, at the point of access patient consent will be required.

Patient Consent

The patient consent model is as follows:

- Access will only be available to clinicians from an organisation with access. They must have a Smartcard log-in. Log-ins will be audited by trusts under their existing policies.
- The clinician, with **a legitimate relationship** with the patient, and **while the patient is with them**, will ask explicit consent to view the detailed care record. Patients have the right to refuse and this will be recorded for future reference.
- In the event of an **emergency** or other instance where the patient is incapacitated and cannot give explicit consent, the clinician will be required to give a reason for viewing, and an alert will be triggered to the Caldicott Guardian.

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.

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.

Testimonials

"I feel that because of being placed in the Commissioning rotation, I was able to think more clearly about individual patient management beyond the consulting room and into the need for referral, prescriptions, costs of services, sick notes, social aspects, family dynamics, access to the services and needs assessments. I was able to put these together with the commissioning angle which I was exposed to sitting in some of the meetings at the CCG where pilots were being approved and the cost and implications of new services were being discussed."

"I plan to work as part of the CCG."

"I was able to realise that clinical assessment and management of patients forms only one point on a list of important skills that was expected and needed to face the challenges of current NHS."

"I feel that there is a strong case to argue that this should become a standard part of training as a formalised rotation across the country; as important as Paediatrics or Psychiatry rotations within General Practice. The future of General Practice lies in the hands of trainees who are not able to appreciate the importance of engagement in designing and implementing services for safe and effective NHS. They are likely to suffer from the tunnel vision of Clinical and Communication skill acumen alone as important skills a GP will need in the future, where clearly these form only part of the arsenal of skills required. "

Creating Social Value means increasing the social, economic and environmental wellbeing of the people we serve.

We will develop a strategy which sets out our approach to implementing the Public Services (Social Value) Act 2012. It will detail the potential of the Act to support NHS Ashford CCG goals, the legislative and ethical imperatives to address social value and that a phased approach to implementation will be taken, which seeks to continuously improve effectiveness.

This strategy will define our first approach to embedding social value and is intended to guide and communicate our commitment to local NHS staff, patients and public, providers, partners and other stakeholders.

Social Value presents a useful framework for NHS Ashford CCG to achieve its goals and meet commitments as set out below…

Strategic and Corporate opportunities to…

- Reduce health inequalities
- Improve health outcomes
- Increase value from commissioning investment
- Use commissioning influence to improve health outcomes

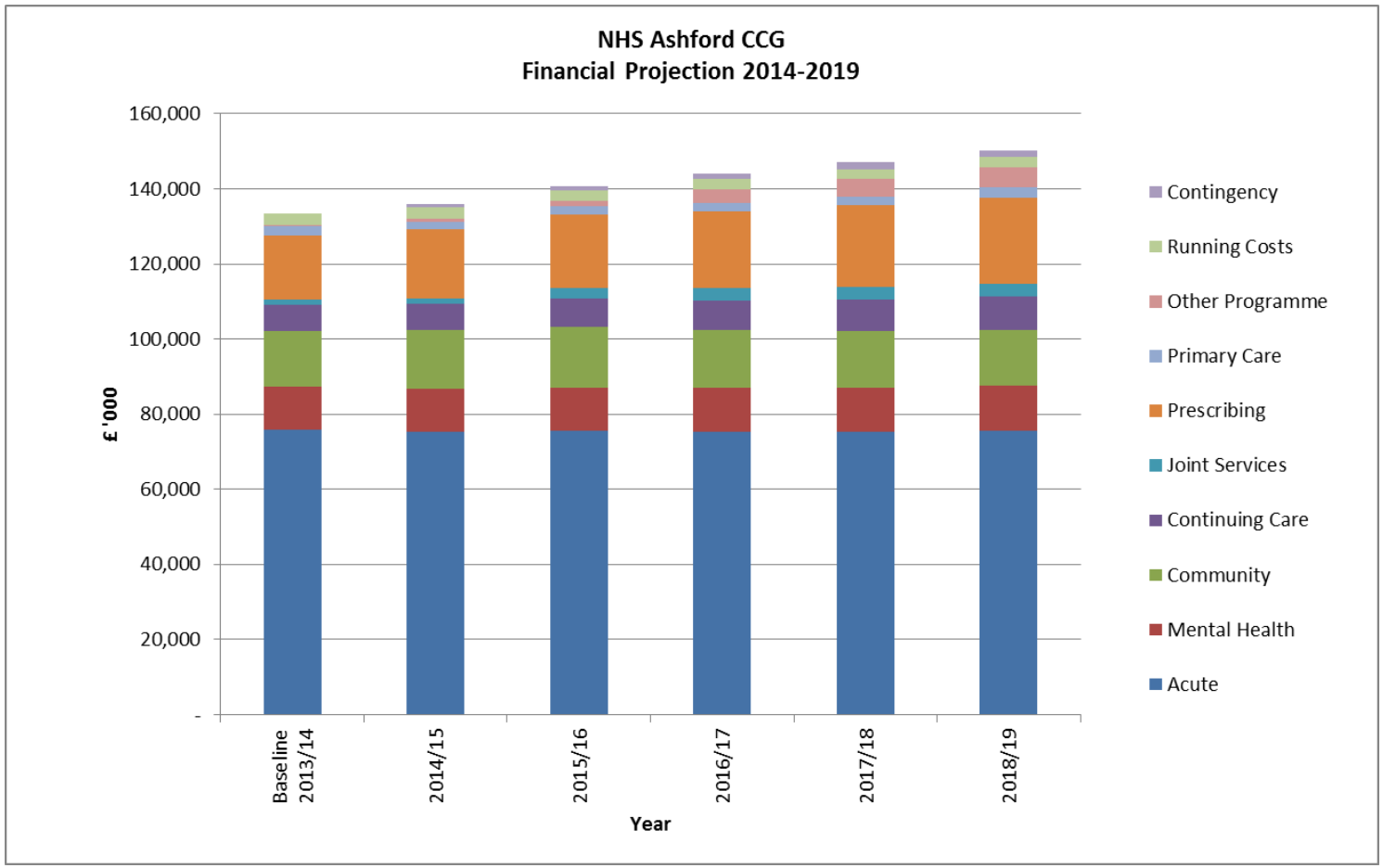
Legislative and corporate requirements

- Public services (social value) Act 2012
- Climate Change Act
- Civil Contingencies Act
- CCG Assurance re Capability and organisational health and Domain 4(e) Environmental & social sustainability
- NHS Sustainability Strategy Nationally

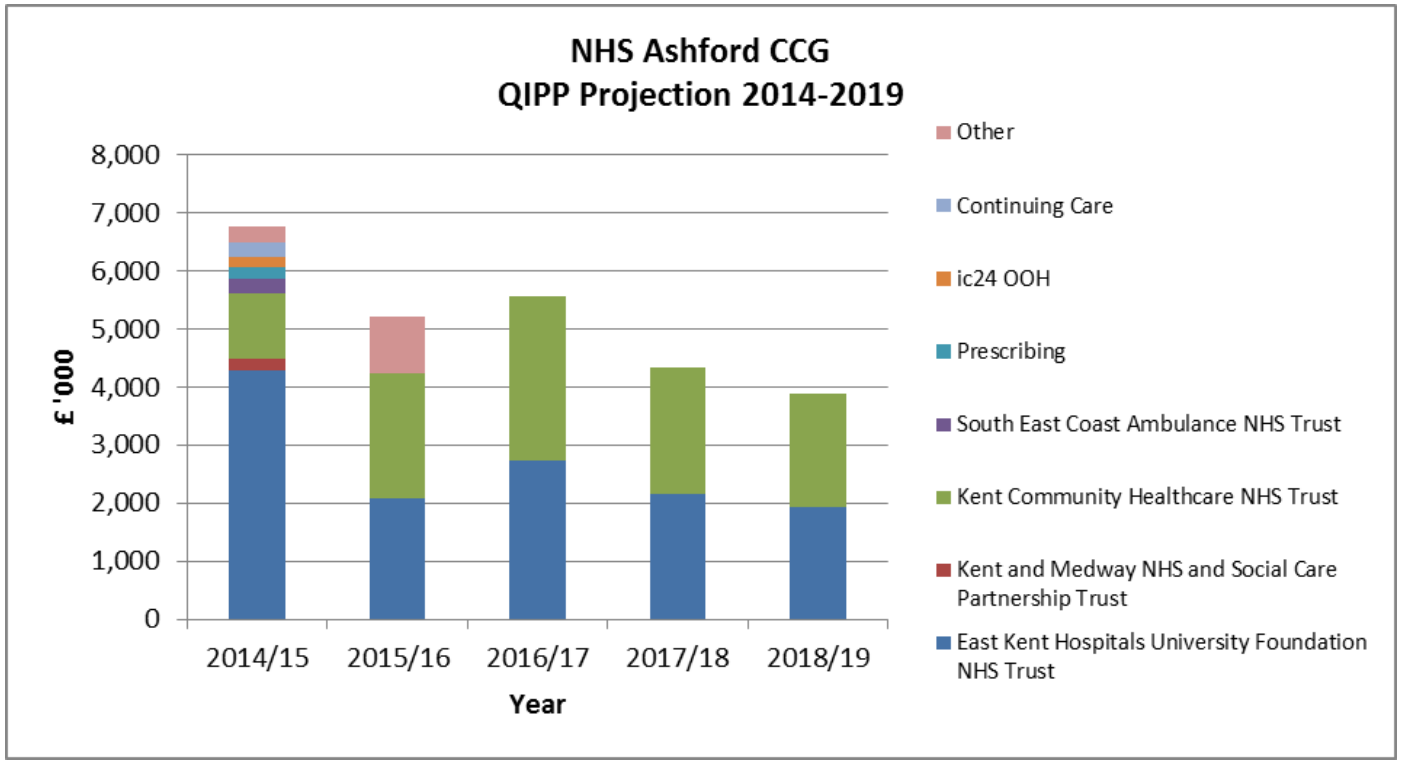
Social Value should…

- Reflect and deliver CCG Vision, objectives and values and support improved health outcomes
- Influence local health economy, healthy population
- Provide leadership for a town wide approach

The CCG budget for 2014/15 is £133m and we are expecting growth on this budget to decline over the 5 year strategy period leading to a budget of £150m in 2018/19. 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 majority of the 2% strategic change funding to support this position.



These are efficiencies that are the direct responsibility of the CCG. NHS financial allocations are expected to rise by around 0-1% each year over the next five years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth would continue at around 6% a year because of the ageing population, new medical technologies and rising expectations. System wide QIPP programmes are the actions required to keep overall growth at an affordable 0-1% level rather than the historical 6%.



Improvement Measures – Five Years

PERFORMANCE INDICATOR	Metric	Baseline		2018/19 Target
Securing additional years of life for the people of England with treatable mental and physical health conditions.	PYLL (Potential years lives lost) per 100,000	**1507.9**		**1229.5**
Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	Health related quality of life for people with long-term conditions (measured using EQ5D tool in the GP Patient Survey).	**75.20**		**76.0**
Reducing emergency admissions	Total emergency admission for the any of the conditions considered avoidable per 100,000 population	**1584.0**		**1540.8**
Number of C.Diff Infections	Calculated annually based on previous year	**TBC**		**24 (in 2014/15)**
Increasing the number of people having a positive experience of hospital care.	The proportion of people reporting poor patient experience of inpatient care	**139.9**		**137.8**
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.	The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	**7.1**		**6.2**
Dementia Diagnosis	% of people diagnosed as proportion of anticipated prevalence	**40.1%**		**75.0%**
Access to Psychological Therapies	Proportion of people having attended two treatment contacts and a moving towards recovery	**TBC**		**55.0%**

Ashford Clinical Commissioning Group

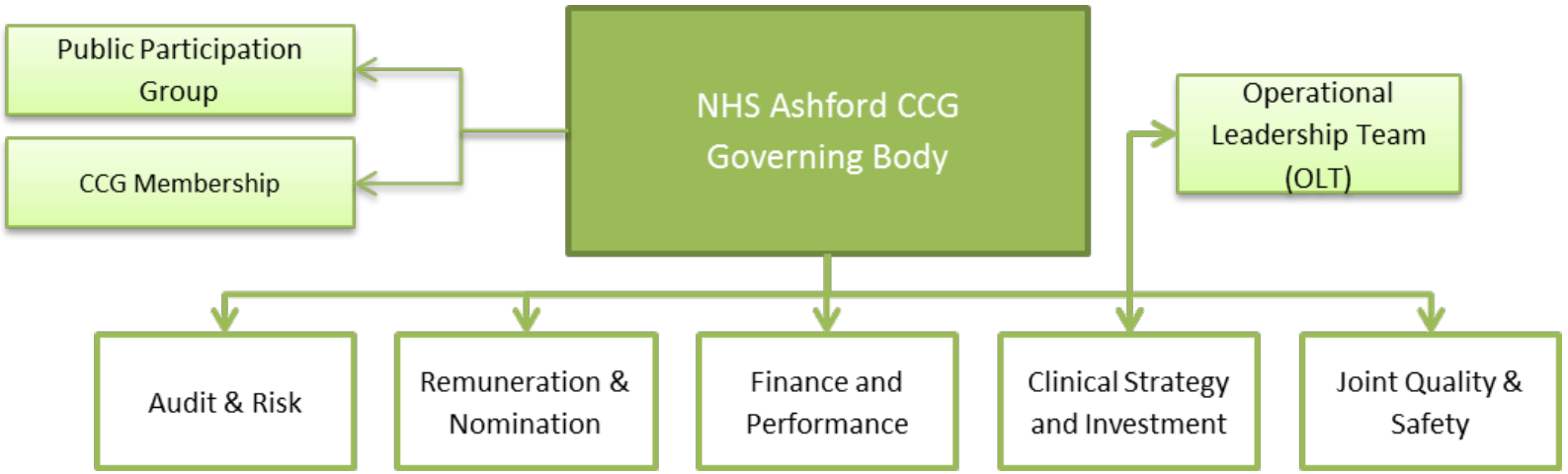
The Next Two Years

2014 – 2016

Operating Plan

To ensure that NHS Ashford CCG remains focused on delivery of its plans throughout 2014/19 and beyond we have implemented 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 and Investment committee meetings



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

The objective of organisation development is to improve the organisation's capacity to succeed in its goals. It seeks to facilitate improved interpersonal and group processes, more effective communication, enhanced ability to cope with organisational problems, more effective decision-making processes, more effective leadership style, improved skill in dealing with conflict, and higher levels of trust and cooperation among members of the organisation. An OD approach places strong emphasis on assessing issues and challenges using robust diagnostic techniques; not making assumptions or too-quick judgments on the solutions to problems.

Building a new vision with supporting strategy and policies

The CCG will build a clear and deliverable vision of how we will transform clinically services and ensure that our plans are strategically aligned with local health and social care commissioners to effect a whole system transformation.

Central to our vision is ensuring clinical leadership of service transformation and services are reformed and reorganised so that both community services and strengthened primary care, integrate with out-of-hospital services to meet patients needs.

We will ensure that our plans are strategically aligned with other health and social care partners and key stakeholders and partners are committed to delivering the our plans.

All of the above needs to be more than aspirations for the CCG and its Governing Body. We will put in place process to ensure the Governing Body's vision is owned by its membership and used to underpin and drive strategic change.

People and Behaviour

In the outline approach we have created Town Teams that will enable the local leadership of the commissioning and transformation of local services, as defined in the community . The new Town Teams operate a matrix model of working where accountability without control and influence without authority will become the normal way of working:

Each Town Team will be provided with the commissioning resources to scale up local services at pace within the overall strategic direction set by the CCG.

To support the devolution of resources and responsibility we will ensure that our systems are clear and credible and deliver improvement to quality and productivity. We will do this by having in place processes for tracking and monitoring outcome based commissioning.

Governance systems will be robust, clinically led and properly constituted. They will operate with complete transparency and accountability and be rigorous enough to withstand challenge. As a commissioning organisation we will remain accountable to our local community.

Organisational Development: Commissioning at Scale

Ashford CCG and Canterbury and Coastal CCG are in their second year as stand alone commissioning organisations. Both organisations are able to demonstrate a track record of success but in their first year of operations did not deliver enough of what they planned to do. This was against a backcloth of an increasingly complex range of stakeholders who need to be engaged in the planning and delivering services.

Both CCGs recognise that they needs to find better ways of working with Local Authority stakeholders and with communities, patients and their carers as co-producers and delivers of care and that this will require a different kind of commissioning organisation that is more responsive and adaptable

The CCGs also recognise that 2014/15 and beyond brings even greater challenges for the CCGs as commissioners. Maintaining the status quo is therefore not an option and the longer organisational restructuring/change is delayed the more difficult it will become.

Merging with Canterbury and Coastal CCG

The membership of Ashford CCG and Canterbury and Coastal CCG are being consulted on a proposal to merge the two organisations. The membership understand the risks of merger through losing local focus and further distancing of local practices from a larger organisation but also understand the risks of not merging:

- The CCGs being limited in their ability to invest additional resources in Town Teams to support primary care in commissioning and provider effort
- Potential gaps appearing in clinical leadership roles that go unfilled
- Continued dilution of senior management team effort by having to operate two CCG
- Loss of focus through operating and delivering two separate commissioning teams
- Opportunities to manage financial risk reduced because of small size of existing CCGs
- The risk that if one CCG begins to fail, critical senior management time is diverted to fire fight thereby compromising the stability of the other

Stakeholder Survey

In March 2014 Unlocked Development surveyed stakeholders on their views on a merger of Ashford CCG and Canterbury and Coastal CCG. Stakeholders included CCG representatives, Local Authority Councillors, Local Authority Officers, Area Team, Local NHS Providers and Local LMC.

In summary the surveys key points are:

- Stakeholders expressed no opposition to the idea of merger and most could see no downside to the idea
- Nearly all recognised the need to achieve economies of scale in commissioning and contracting and recognises that a merged organisation will have more commissioning muscle and leverage with providers
- The need to ensure that effort and resources put into delivering the merger does not distract from delivering business as usual
- The importance that the merger is happening for the right reasons
- Appropriate Governance arrangement were seen to be critical

Overall responsibility for quality lies with the NHS Ashford CCG Governing Body, it is driven by the Chief Nurse and the CCG Quality Committee to ensuring that high quality safe care is at the forefront of the organisation.

NHS Ashford CCG aims to put the patient at the centre of all that we do and as such believe that quality underpins all that we strive to achieve.

The Chief Nurse provides assurance to the Governing Body at every meeting in relation to:

Patient Safety

Health Care Associated Infection (HCAI), safeguarding reviews and Domestic Abuse; safe workforce; serious incidents and never events, quality accounts, intelligence and risk, National Safety Thermometer

Clinical Effectiveness

NICE compliance, research and development, mortality data, medicines management, clinical pathway quality reviews, clinical audit, staff training and development

Patient Experience

Patient Experience (feedback), Commissioning for Quality and Innovation (CQUINS), CQC compliance, Safe Care and Compassion, Complaints

Our Aims

- All patients/users experience dignified and compassionate care.
- We listen to any concerns of the public, patients and carers and use their feedback to inform our decision making.
- To maintain and improve the safety and effectiveness of all commissioned services, and ensure that they meet the necessary standards of quality, and enhance the patient experience.
- To deliver on the national and local health outcomes priorities for 2014-19 and beyond.

Our Approach

- To use hard and soft intelligence to identify risks to patients and staff and understand at an early stage if there are any concerns in any service or provider organisation.
- To promote a culture of transparency,
- To develop a robust schedule of Quality visits to all providers
- To harness shared learning within the CCG for the benefit of all parties.
- To maintain and promote access to all, ensuring services help to reduce social inequalities and improve access for vulnerable or excluded groups.
- To ensure that the right quality governance mechanisms are in place to provide assurance

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

Francis Report

NHS Ashford CCG will, through its governance and assurance process, secure an effective whole system response to the Francis enquiry reporting to the Governing Body on how it is responding to the five main principles of:

- Fundamental standards of care where non-compliance should not be tolerated
- Openness transparency and candour in every healthcare organisation
- Proper standards of nursing care ensuring that no one should provide hands on care that is not properly trained and registered.
- Strong patient-centred leadership where local leaders are held to account for failures.
- Accurate and useful information available to demonstrate compliance with fundamental standards.

The CCG will expect providers to:

- Develop and refresh action plans underpinned by the recommendations of Francis (2013). These will be presented at the Quality Meetings that are held with providers.
- Demonstrate that nursing, midwifery and care staffing are underpinned by the recommendations made by the National Quality Board: *How to ensure that the right people, with the right skills, are in the right place at the right time* (2013).

Berwick Report

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

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

NHS Ashford CCG will undertake to support the recommendations made by Berwick, (in summary):

- Placing the quality of patient care, especially patient safety above all aims.
- Fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.
- Embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

Winterbourne Report

The Winterbourne Report is a national response to Winterbourne View Hospital following the uncovering of years of physical and psychological abuse of patients with learning disabilities (LD) and challenging behaviour

- Highlighted the need to stop hospitals becoming homes for LD patients
- CCG responsible for jointly reviewing with local authority partners all patients in NHS funded in-patient LD facilities
- CCG responsible for finding supported community placements with appropriate personal care planning in place for these patients

NHS Ashford CCG is committed to implement the recommendations of Winterbourne View findings.

A Kent Winterbourne Working Group involving Kent County Council, Kent and Medway Partnership NHS Trust and Kent Community Health NHS Trust has been established to consider the current and future need and demand for specialist community and in-patient services for people with learning disability or autism.

Safeguarding

Maintaining a focus on safeguarding for the most vulnerable groups is a priority concern for NHS Ashford CCG and the organisation will work in partnership with all stakeholders to ensure statutory responsibilities are undertaken as effectively as possible. In particular:

- To host designated safeguarding leads for both adult and child within the CCG with direct access to the chief nurse to share and escalate concerns.
- Quality In Care homes project
- To host CAF (Common Assessment Framework) completed by health Services on behalf of vulnerable children and families.
- Learning disabled residents care and placements are reviewed in response to the Winterbourne View Findings.
- Chief Nurse ensures the CCG has a designated representative to the Safeguarding Adults Board and Health Safeguarding Group (a Sub group of Kent Safeguarding Children Board)
- Designated doctor for safeguarding children and a designated paediatrician for unexpected deaths in childhood provide CCG advice and support
- Assurance in place for providers meeting safeguarding child and adult training.

We will continue to work closely with our local authority partners to continually improve the safeguarding of children and vulnerable adults and to continue to be active members of the local safeguarding boards to maximise opportunities for greater coordination and integration of adult and children's safeguarding arrangements

Hospital Acquired Infections

We will continue to reduce the number of Health Care Associated Infections (HCAIs) through the implementation of local action plans and we remain committed to a zero tolerance approach. We will employ expert resource in this field to bridge the gap between primary and secondary care and ensure that learning can be embedded throughout the health and social care sector.

Management of Serious Incidents (SI) and Never Events

All Serious Incidents and never events are reviewed and discussed by the quality committee. The administration of these is supported by KMCS to allow Kent wide learning and early identification of any trends. The CN together with the Quality Lead monitor these alerts and ensures the providers act accordingly to review and understand the root causes of the SI and ensure that action plans are in place to minimise recurrence.

We will encourage a culture of transparency, openness and candour across the health system, to ensure that staff, patients and carers feel safe and secure when raising concerns and that we learn from patient safety incidents and 'never events' to prevent them from happening again.

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..

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

From	Change Project	To
"I do not know who is in charge of my care" "It would be helpful if the different people involved in my care talked to each other and knew what the others were doing" "I panic when I have a crisis, who should I contact? Will they know my wishes?" "I feel that I need to depend on others for my care and cannot live my own life, independent." "When the consultant or nurse discharges me, I don't know what happens next."	• **Integrated Urgent Care Service –** Multi-disciplinary service within hospital consisting of GP, Hospital Specialists, Mental Health and Health and Social Care Teams. Improving the co-ordination and flow of patients through the urgent care system, with 24/7 care co-ordination centre and enhanced ambulatory care services. • **Cluster Teams -** Extend Cluster Team approach, offering extending hours • **Enhanced Support to Care Homes –** An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes • **Mental Health –** Primary Care MH Specialist pilot, Community link workers in primary care, Targeted community development work • **Winterbourne –** Implementation of joint plan with KCC, discharge of patients currently within in-patient facilities to community placements with providers able to support people with complex needs • **End of Life –** Improved co-ordination and timeliness of care, Palliative care education programme, Increased specialist bereavement counselling service, Procurement of system wide electronic palliative care system • **Falls Pathway –** Implementation of falls pathway to include prevention, treatment and ongoing support	"I feel confident that I am in control of my own care, supported by my GP" "Everyone seems to know what is happening with my care. Clearly they talk to each other." "I had the details of a single contact and everyone else could see my preferred treatment options electronically." "I am supported to live my life how I wish because I know that support is there when I need it." "Whenever I had to see someone new, there was a plan for my care and they could see my records"

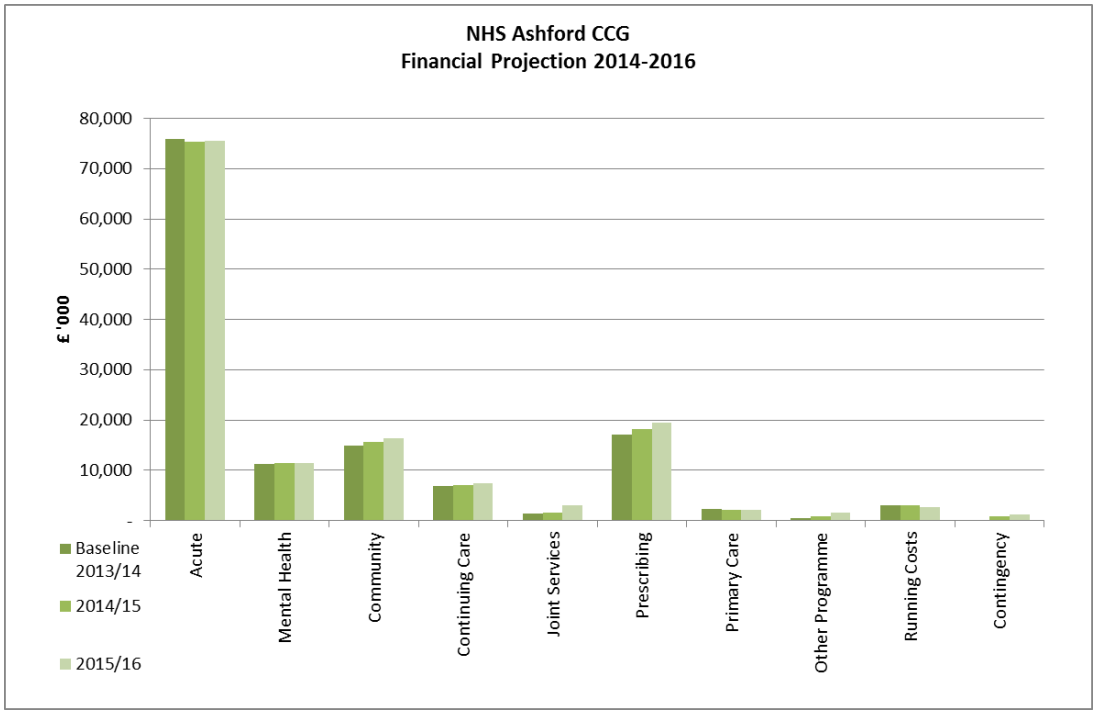
From	Change Project	To
"I spend too much time travelling to hospital with additional costs of parking" "I only have a quick review of my care, once a year" "What happens when my child becomes an adult, who will care for them then?" "My GP wasn't sure where to refer me for my condition." "Why should I wait until my illness becomes unmanageable before I am offer assistance."	• **One-stop outpatient services –** Urology, Breast, Colorectal one-stop services across East Kent • **Community DVT Service –** town based model integrated with existing MIU facilities • **Diabetes -** Type 2 Diabetes primary care training programme, Integrated Diabetes care pathway implementation • **Anti-coagulation Services -** Re-procured model ensuring both initiation and on-going monitoring within the community • **Gastroenterology –** Introduction of faecal calprotectin testing in primary care • **Dermatology** – Review of community pathway with a view to re-procuring service, reducing fragmentation in current pathway • **ADHD –** Re-procurement of community specialist "all age" ADHD service, reducing need to transition across paediatric and adult services • **Eating Disorders -** 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	"I only had to visit the hospital once, the rest of my care was offered locally." "I now only attend the hospital when it is necessary to change my treatment." "I didn't notice a change when my child reached adulthood, the care carried on with the same people." "The GP had clear information on his system showing what my options were." "My condition was picked up quickly and I was supported early. Consequently I was able to control my condition."

From	Change Project	To
"I needed help last night when my carer had to go into hospital. I cannot cope alone with my dementia." "When I had problems in my pregnancy, I had to go to A&E, this really wasn't where I wanted to be." "All we needed to Mum to go home was the right equipment. This took days to arrive and so she was stuck in hospital" "Why do I always have to go to hospitals for my eyes when there is an Optometrist down the road?"	• **Dementia –** New out-of-hours service for older people with Mental Health problems and Dementia • **Early Pregnancy –** Improve awareness of pathway and services to reduce the level of EPAU in A&E • **Transformation of Acute Children's Services** - New urgent and emergency care clinical network for children and young people, using assistive technology. Working with Public Health and the School Nursing Service to deliver key messages in schools. • **Cardiology -** Reducing fragmentation in the patient pathway. To improve health outcomes through earlier diagnosis and treatment of common cardiology conditions offering better clinical effectiveness and increase quality of service • **Community Loan Store -** Procure joint social and health care loan store service, implementing seven day working offering a faster, more responsive, service appropriate to patient need • **Ophthalmology –** Review of hospital eye services with a view to re-procurement of specific pathways suitable for management in the community. Macular Oedema – A central acute site to deliver treatment and drug administration, with hub and spoke community model to provide monitoring	"When my carer was admitted, the NHS stepped in to make sure I had support." "I was able to access the Early Pregnancy Unit and had my scan took place straight away. " "The equipment turned up the next day and Mum was back home where she wanted to be." "I saw the consultant for my eye problem once and now I go to see my usual optometrist and that is so much more convenient."

In 2014/15 and 2015 /16 the main challenge and risk concerns delivery of planned benefits from new quality, innovation, productivity and prevention (QIPP) schemes totalling £6.7m and £5.2m respectively and accounting for over 5% of the resource limit (after the full year effects of previous schemes are added). The key themes include integrating health and social care as well as providing an integrated urgent care service to navigate the health system for the benefit of patients, whilst avoiding unnecessary admissions. Several projects underpin these key strategic aims and the CCG is establishing a rigorous programme management process to ensure delivery.

Contingency

It is assumed that the contingency will be absorbed during the year to support the CCG's positions around its main contracts. Although potentially leaving little headroom for unexpected risks, this should be significantly mitigated by the nature of the agreement with EKHUFT currently being negotiated. The CCG also has to absorb a £0.9m contribution to the NHSE risk share pool in respect of legacy CHC provisions.



Better Care Fund:

The CCG is setting aside £2.5m in 2014/15 to enable key projects for the Better Care Fund. There is a close relationship with the QIPP programme and an emphasis upon initiatives to join up health and social care. In 2015/16 the CCG contribution increases to £8.9m plus an allocation of £3.7m. This significant re-direction of funds must be invested (together with other stakeholders) to deliver immediate financial benefits if the CCG is to continue to meet its target surplus requirement.

Central to our strategic vision is an ambition to ensure that all of our patients receive the highest quality care. The Commissioning for Quality and Innovation (CQUIN) payment framework ties part of a provider's income to quality and innovation requirements. These requirements - known as CQUINs - cover a whole range of areas, including training to ensure that staff get the updates they need and Friends and Family results that look at patient experience and satisfaction.

In addition to the nationally defined incentives, during 2014-2016, we have decided to have four local measures, shared across both our community and acute providers. Our local quality incentives are designed to focus on specific local health needs, support the integration between providers and drive the system change we need to secure a health system which is fit for the future.

COPD	Over 75s (with Long Term Condition)	Diabetes	Heart Failure
2014/15	2014/15	2014/15	2014/15
Work collaboratively to analyse the current COPD pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.	In relation to Share my Care (SMC), working with all contributors to the pathway, agree standard documentation to upload to SMC and responsibilities within this process. Agree a standard set of information to be uploaded and maintained on SMC.	Working with acute colleagues to analyse current pathways, in comparison to the new pathway identified by the CCG's. Identify areas which need change and undertake that change to deliver the new model within agreed contract.	Work collaboratively to analyse the current Heart Failure pathway of care provided by the Community Trust and the Acute Hospital Trust to identify gaps and issues and agree a future integrated pathway and outcome measures.
2015/16	2015/16	2015/16	2015/16
Work collaboratively to embed and measure performance of new integrated care pathway for COPD patients, with ultimate aims being to reduce non-elective admission/readmission by; • Delivering care close to home • Improving transfer of care • Improving self-management	Embed and measure performance, with ultimate aims being to; • Develop a collaborative shared care plan approach • Improve transfer of care between providers • Improve the safety and quality of patient care	Embed and measure performance, with ultimate aims being to reduce non-elective admission/readmission by; • Delivering care close to home • Improving transfer of care • Improving self-management	Work collaboratively to embed and measure performance of new integrated care pathway for Heart Failure patients, with ultimate aims being to reduce non-elective admission/readmission by; • Delivering care close to home • Improving transfer of care • Improving self-management

Improvement Measures – First Two Years

PERFORMANCE INDICATOR	Metric	Baseline	2014/15 Target	2015/16 Target
Securing additional years of life for the people of England with treatable mental and physical health conditions.	PYLL (Potential years lives lost) per 100,000	**1507.9**	**1447.6**	**1389.7**
Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	Health related quality of life for people with long-term conditions (measured using EQ5D tool in the GP Patient Survey).	**75.20**	**75.4**	**75.5**
Reducing emergency admissions	Total emergency admission for the any of the conditions considered avoidable per 100,000 population	**1584.0**	**1575.3**	**1566.6**
Number of C.Diff Infections	Calculated annually based on previous year	**TBC**	**45**	**TBC**
Increasing the number of people having a positive experience of hospital care.	The proportion of people reporting poor patient experience of inpatient care	**139.9**	**139.5**	**139.1**
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.	The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	**7.1**	**6.9**	**6.7**
Dementia Diagnosis	% of people diagnosed as proportion of anticipated prevalence	**40.1%**	**67.0%**	**75.0%**
Access to Psychological Therapies	Proportion of people having attended two treatment contacts and a moving towards recovery	**TBC**	**50.0%**	**55.0%**

National Outcome Indicators				Local Priorities					
	Seven Outcome Ambitions	Strategic Risks	Measures	Urgent Care	Planned Care	Mental Health	Community Network	Child Health and Maternity	Primary Care
1	Securing additional years of life for the people with treatable mental and physical health conditions	Failure to delivery key projects aimed at reducing health inequalities will result in the continued health gap between the poorest and the most affluent wards	PYLL (Potential years lives lost) per 100,000			✔	✔	✔	✔
2	Improving the health related quality of life of people with one or more long-term condition, including mental health conditions	Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	Health related quality of life for people with long-term conditions (measured using EQ5D tool in the GP Patient Survey).	✔	✔	✔	✔	✔	✔
3	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Systems across services not integrated and therefore do not enable shared care plans between organisations to support integrated outcome measurement and monitoring.	Total emergency admission for the any of the conditions considered avoidable per 100,000 population	✔	✔	✔	✔	✔	✔
4	Increasing the proportion of older people living independently at home following discharge from hospital.	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / home care activity by 2015/16, impacting the overall funding available to support care services and future schemes	No indicator available at CCG level.	✔	✔		✔		✔
5	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Shifting resources to fund new schemes may destabilise current services and providers, particularly in the acute sector.	The proportion of people reporting poor patient experience of inpatient care	✔	✔	✔		✔	
6	Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community.	Patients and providers may not know how to access services within an integrated system to ensure services are used appropriately	The proportion of people reporting poor experience of General Practice and Out-of-Ours Services	✔	✔	✔	✔	✔	✔
7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	Shifting resources from acute services may lead to a reduction in the right people, with the right skills, being in the right place at the right time	Indicator in development	✔	✔			✔	
8	Ensuring a sustainable financial future and good governance	Non-delivery of the projects within this programme will have significant effect on the CCG's ability to meet its statutory obligations. The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable.	Non qualified annual accounts	✔	✔	✔	✔	✔	✔
9	Achieve objectives through effective stakeholder engagement, public engagement and partnership working	The CCG may suffer reputational damage if we fail to deliver the outcomes detailed.	Recognised as the local leader of the NHS (Social Capital)	✔	✔	✔	✔	✔	✔

Annex A: Plan on a Page

"Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector."

- Securing additional years of life for the people with treatable mental and physical health conditions.
- Improving the health related quality of life of 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 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.
- Ensuring a sustainable financial future and good governance
- Effective stakeholder engagement, public engagement and partnership working.

Primary Care	We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.
Community Networks	Primary and community care services working closer together, along with voluntary organisations and other independent sector organisations.
Mental Health	We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities
Urgent Care	We want care that crosses the boundaries between primary, community, hospital and social care.
Maternity, Children and Young People	We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation
Planned Care	We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

Governance

- Governing Body and supporting committee structure
- Kent Health and Wellbeing Board
- Canterbury and Coastal Health and Wellbeing Board with supporting sub-group structure
- Whole Systems Delivery Board
- Public Reference Group
- Programme Boards for Urgent and Planned Care
- Programme Management Office

Success Criteria

- Delivery of improvements against NHS Operating Framework Domains
- Achievement of financial stability and balance
- People are supported to live in their own homes or communities.
- We will see less acute admissions and reduced length of stay.
- 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

High Level Risks

- Ensuring that we have a workforce with skills to deliver integrated care.
- Ability of providers to respond to competing priorities
- Maintaining quality and safety during period of service transformation
- Achievement of financial balance
- Public support for change programme

Military personnel put themselves in harm's way in the service of their country. The health service's obligations to our armed forces were recently set out in the *2011 Armed Forces Covenant*, the key component being that our armed forces shouldn't face an disadvantage in accessing timely, comprehensive and effective healthcare and that they receive bespoke services for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation. Whilst the majority of services for our military are commissioned by the Ministry of Defence, the CCG is responsible for commissioning services required by Armed Forces' families where registered with a local GP Practice, and services for veterans and reservists when not mobilised. Bespoke services for veterans, such as veterans' mental health services, are also commissioned by the CCG

Armed Forces Network

In line with the NHS Operating Framework, Regional Armed Forces Networks have been set up across the country. The South East Coast Armed Forces Network was launched in February 2011, and covers Kent, Surrey and Sussex. The stated aims of the South East Coast Armed Forces Network are:

- To provide regional NHS leadership, advocacy and points of liaison for military health and veterans issues.
- To work with regional military, social services and third sector organisations to ensure delivery of armed forces community programmes

Veterans/Ex-Services Personnel Rights

The term veteran is itself controversial, since such a large proportion of so-called veterans would not describe themselves as such. Younger members of this population would perceive the word veteran as applying to the World War Two veterans who are so visible at national veteran events. This cohort would be more likely to identify themselves as 'ex-military' or 'ex-service'.

A veteran is someone who has served in the armed forces for at least one day. There are around 9,000 veterans in the Ashford Area. All veterans are entitled to priority access to NHS hospital care for any condition as long as it's related to their service, regardless of whether or not they receive a war pension.

The CCG has an identified **Forces Champion** with the role of signposting and promoting services available to ex-military personnel.

Our vision is to obtain the best heath benefit from the available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

System Values

To achieve our vision we will:

- Work with Defence Medical Services to support them in their task of ***promoting, protecting*** and ***restoring*** the health of the Defence population in order to maximise fitness for role. We will achieve this by commissioning a comprehensive core service.
- Make evidence based decisions
- Listen to and learn from patient experiences
- Ensure that Armed Forces personnel are not disadvantaged in their access to healthcare be that offer, access or outcome
- Ensure that special consideration is given to those injured as a proper return for their sacrifice

System Objective One
Services for the armed forces are commissioned to achieve the best health outcomes, in line with the commitments of the Armed Forces Covenant

System Objective Two
We work in partnership with the MoD to commissioning healthcare in line with the partnership agreement and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role.

System Objective Three
We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive

System Objective Four
We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong armed forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner

Delivering better care through the digital revolution
(a) increase use of E-referrals, including advice and guidance functionality, within DPHC
(b) increase the use of telemedicine as an alternative to face to face care where appropriate;
(c) increase access to national screening programmes
(d) link DMS systems to Child Health Information Systems

Co-ordinated access to musculoskeletal pathway
(a) Improved use of E-referrals and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
(b) re-design MSK pathways to make best use of recognised good practice in rehabilitation

Improved access to mental health services
(a) Improve care co-ordination on service discharge
(b) Improve signposting to appropriate mental health services including crisis services
(c) Improve choice of recognised good practice services for mental health such as online counselling

WIS leavers to have an agreed health plan
Work with the MoD to ensure that all WIS service leavers leave with a personal health plan; designed to empower patients to take to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs.

Overseen through following governance arrangements

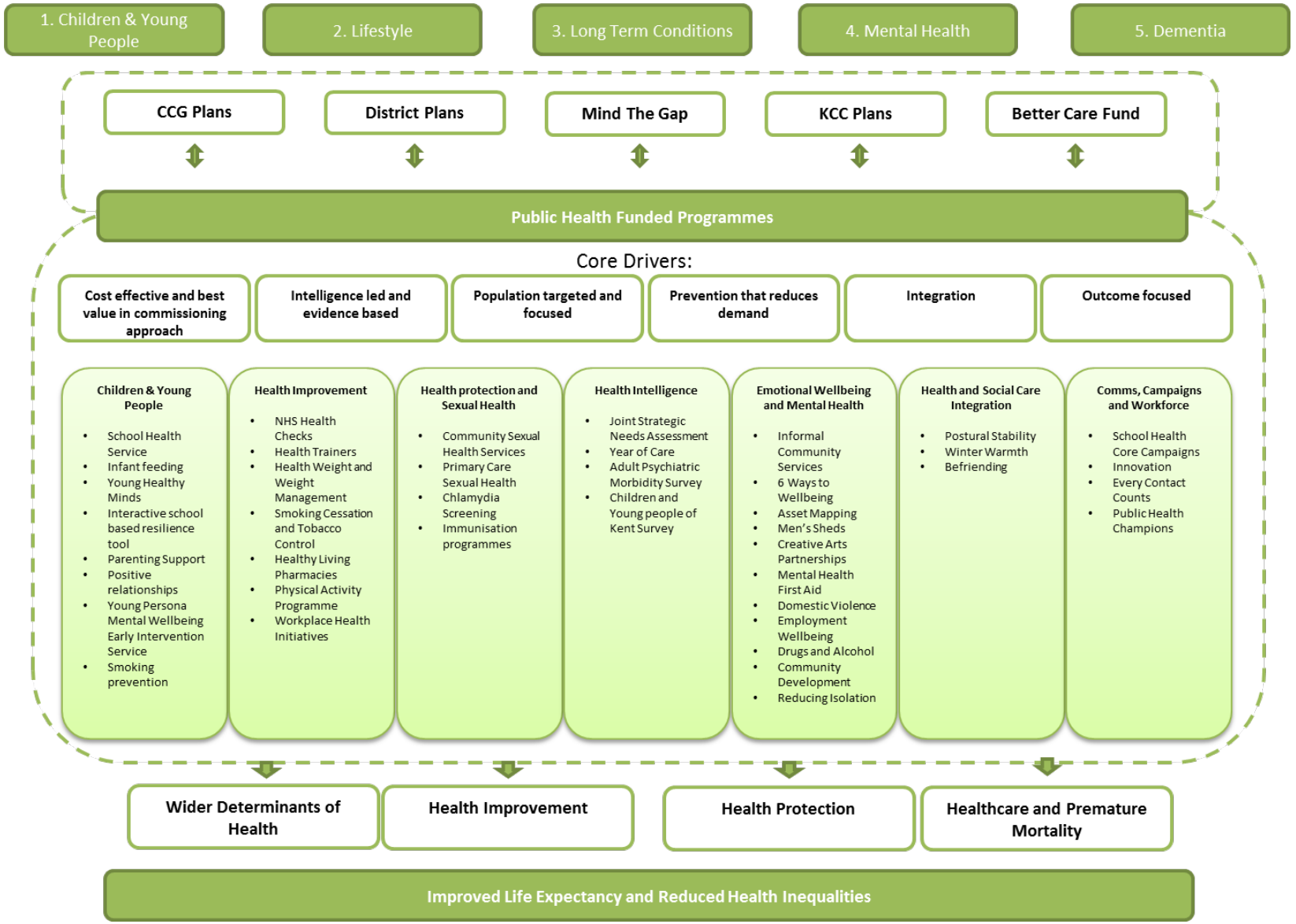
- Area Team internal meetings
- Armed Forces Operational Group
- Joint Commissioning Group
- Armed Forces Oversight Group

Measurement

- Increased referrals made electronically
- Sustained RTT performance
- Co-produced workforce measures
- Access to screening programmes
- Number & % of agreed health plans
- Register of Armed forces champions
- Mental Health services directory

Sustainability

- We will consider sustainability and affordability in our approach to decision making.
- We will work with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability.


1. Children & Young People
2. Lifestyle
3. Long Term Conditions
4. Mental Health
5. Dementia
CCG Plans
District Plans
Mind The Gap
KCC Plans
Better Care Fund
Public Health Funded Programmes
Core Drivers:
Cost effective and best value in commissioning approach
Intelligence led and evidence based
Population targeted and focused
Prevention that reduces demand
Integration
Outcome focused
Children & Young People
School Health Service
Infant feeding
Young Healthy Minds
Interactive school based resilience tool
Parenting Support
Positive relationships
Young Persona Mental Wellbeing Early Intervention Service
Smoking prevention
Health Improvement
NHS Health Checks
Health Trainers
Health Weight and Weight Management
Smoking Cessation and Tobacco Control
Healthy Living Pharmacies
Physical Activity Programme
Workplace Health Initiatives
Health protection and Sexual Health
Community Sexual Health Services
Primary Care Sexual Health
Chlamydia Screening
Immunisation programmes
Health Intelligence
Joint Strategic Needs Assessment
Year of Care
Adult Psychiatric Morbidity Survey
Children and Young people of Kent Survey
Emotional Wellbeing and Mental Health
Informal Community Services
6 Ways to Wellbeing
Asset Mapping
Men's Sheds
Creative Arts Partnerships
Mental Health First Aid
Domestic Violence
Employment Wellbeing
Drugs and Alcohol
Community Development
Reducing Isolation
Health and Social Care Integration
Postural Stability
Winter Warmth
Befriending
Comms, Campaigns and Workforce
School Health Core Campaigns
Innovation
Every Contact Counts
Public Health Champions
Wider Determinants of Health
Health Improvement
Health Protection
Healthcare and Premature Mortality
Improved Life Expectancy and Reduced Health Inequalities

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.

Delivering the policy objectives set out in the Marmot Review requires action by central and local government, the NHS, the third and private sectors and community groups .

The Kent-wide health inequalities action plan (Mind the Gap, Building Bridges to Better Health for All) provides strategic direction and a shared commitment to reducing inequalities. The Action Plan is aligned to existing national programmes, Kent's Joint Strategic Needs Assessment, Sir Michael Marmot's objectives for reducing inequalities and the recent Public Health Outcomes Framework to ensure that priorities and commitment are owned and achievable.

The local level Health and Wellbeing Board, detailed elsewhere within this plan, provides opportunities for the CCG, Kent County Council and our District Councils to work collaboratively to reduce health inequalities across the CCG.

NHS England has set out its plan for a small number of national networks to improve health services for specific patient groups or conditions. Called strategic clinical networks, these organisations will build on the success of network activity in the NHS which, over the last 10 years, has led to significant improvements in the delivery of patient care.

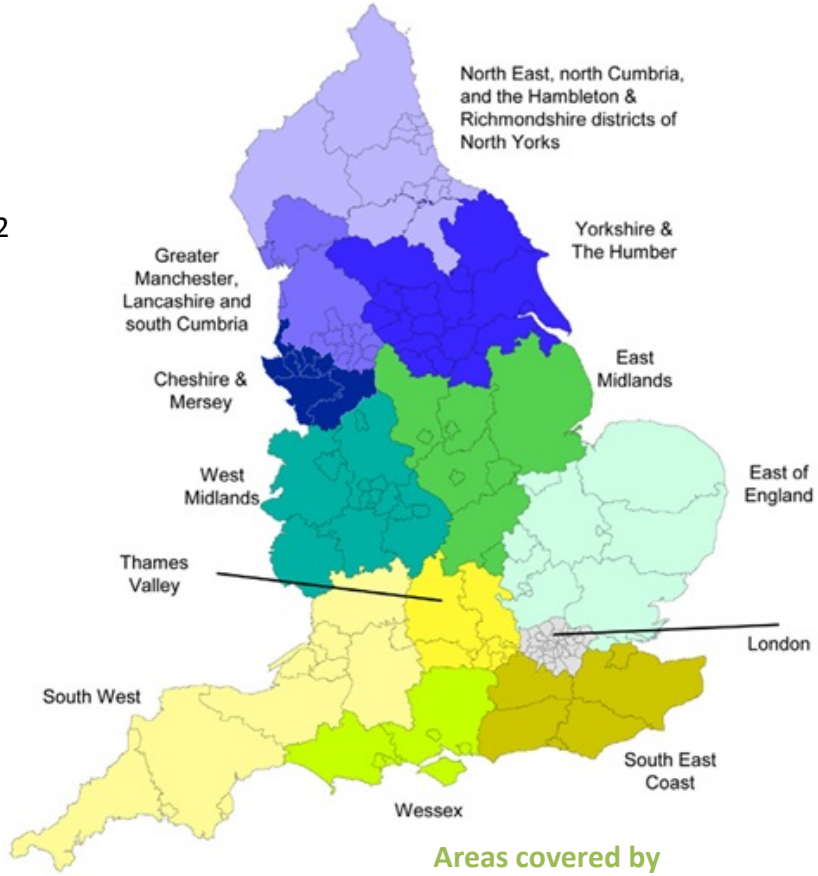
Strategic clinical networks, hosted and funded by the NHS England, will cover conditions or patient groups where improvements can be made through an integrated, whole system approach. These networks will help local commissioners of NHS care to reduce unwarranted variation in services and encourage innovation.

These networks will exist for up to five years and will be managed by 12 locally based support teams. These teams will build and oversee effective network arrangements for their area and help networks develop an annual programme of quality improvement in local services

The conditions or patient groups chosen for the first strategic clinical networks are:

- Cardiovascular Disease
- Cancer
- Maternity and Children's Services
- Mental health, dementia and neurological conditions

Combining the experience of clinicians, the input of patients and the organisational vision of NHS staff they have supported and improved the way we deliver care to patients in distinct areas, delivering true integration across primary, secondary and often tertiary care. For example, stroke networks have enabled transformation in the way services are delivered in many parts of the country leading to measurable improvements in both outcomes and experience for patients.



Areas covered by Strategic Clinical Networks

Strategic Clinical Network: Cancer

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved Cancer healthcare outcomes across Kent, Surrey and Sussex. Improved patient experience and safety underpin all our work programmes

Objective: The prevention of premature morbidity and mortality from cancer, matching the levels of the best in Europe (Outcome Domain 1)

Delivered through a programme of raising awareness and earlier diagnosis of cancer

- A review of referral rates, emergency presentation, stage of disease at diagnosis (May 2014)
- Review current uptake rates of direct access within primary care in order to identify areas for improvement (September 2014)
- Work with primary care colleagues to describe optimal clinical practice and systems with a case for change to ensure streamlined diagnostic/cancer pathways (2015)
- A targeted local education programme agreed for GPs (September 2015)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- Cancer programmes and improvement interventions overseen by Cancer Steering Group
- Project task and finish groups overseen by Clinical Advisory Groups, patient and public and commissioner forums

Objective: To improve survival and health outcomes for cancer patients related to cancer treatment (Outcome Domain 3)

Delivered through a programme that ensures patients are as fit as possible to undergo and recover from cancer treatment

- Developed treatment protocols for the physical optimisation of patients with cancer as they progress through treatment, e.g. chemotherapy, radiotherapy and surgery (September 2015)

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care quality, identified in 2013 baseline reviews

Objective: To increase patients' ability to self-manage their recovery (Outcome Domain 2)

Delivered through implementation of the "Recovery Package"

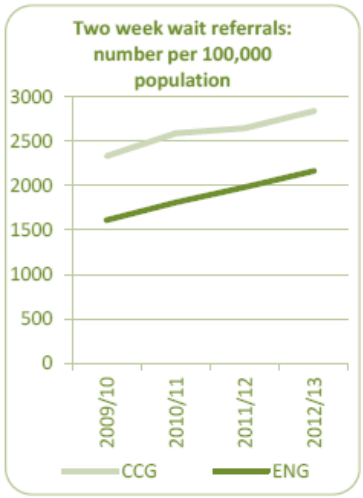
- Audit current practice of Holistic Needs Assessment and care planning, Treatment Summaries and cancer reviews, and patient education and support events (September 2014)
- Address variation in Holistic Needs Assessment and care planning (March 2015)
- Shared care Treatment Summaries agreed between primary and secondary care (March 2015)
- Framework for patient education and support events agreed (June 2015)
- Encourage adoption of EPaCCS across SEC and improvement of ACP (April 2015)

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation
- We will contribute towards delivering NHS England's commitment to 'parity of esteem'

The Cancer Awareness and Early Diagnosis dashboard produced by the Quality Observatory and South East Coast Cancer SCN brings together a number of measures on one page with the aim of providing an overall picture of performance by CCG.

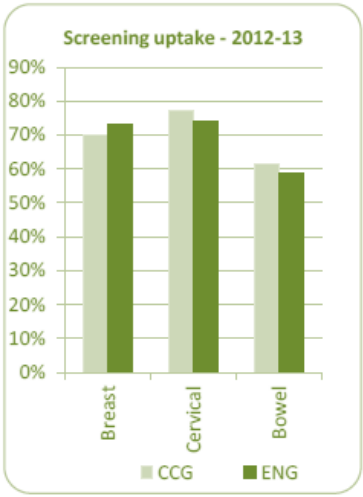
Two week wait referrals
Ashford CCG has a higher rate of referrals than the national figure, which may be an indication of a higher percentage of over 65s in the locality than the England average



Emergency admissions with cancer per 100,000 population
Ashford CCG has a lower rate of emergency cancer admissions than the national average, despite the age profile .

Two week wait referrals with cancer: conversion rate
The conversion rate is the number of Two Week Wait referrals subsequently diagnosed with cancer. Ashford CCG's figure of 9% is one of the lowest in the Kent, Surrey and Sussex region where CCG rates range from 6% to 13%. This is also lower than the national average.

Screening uptake (breast, cervical, bowel)
For breast screening, CCG uptake rates in Kent, Surrey and Sussex range from 49% to 77%. Ashford has an uptake rate of 70% so below the average for the region.



Uptake rates for cervical screening in the region range from 72% to 79%. The CCG has one of the higher rates with an uptake of 77%.

For bowel screening, regional uptake rates range from 56% to 66%. Ashford is towards the higher end of this range with a rate of 62%.

National Cancer Patient Experience Survey
Question1 asks how many times a patient saw their GP before being told they needed to go to hospital. 81% of patients from East Kent saw their GP once or twice, indicating relatively high levels of early diagnosis in the area.

Strategic Clinical Network: Cardiovascular

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved cardiovascular (cardiac, stroke, renal and diabetes) healthcare outcomes across Kent, Surrey and Sussex. Improved patient experience and safety underpin all our work programmes

Objective: The prevention of premature morbidity and mortality from cardiovascular disease (Outcome Domain 1)
Transformational programme that increases the earlier detection ability of Primary Care

Delivered through a programme of raising awareness and earlier diagnosis of cardiovascular disease

- SEC NHS Health Check Forum supported to increase offer and uptake rate of NHS Health Checks (2018)
- NICE anticoagulation guidelines agreed across SEC for Atrial Fibrillation (September 2014)
- Guidelines for clinicians for AF management (December 2014)
- Case for change model for identification, diagnosis and treatment of AF (December 2014)
- Guidance on Standards for Chronic Kidney Disease (CKD) identification and referral advice systems in primary care (2014-15)

Objective: To improve the quality of life after illness from cardiovascular disease and optimising cardiovascular health (Outcome Domain 2)

Delivered through a programme on optimising care for those living with cardiovascular disease

- Case for change for best practice heart failure model (March 2015)
- Cases for change for diabetes integrated care models, foot care pathways and patient empowerment (2014-15)
- Encouragement of adoption and improvement of EPaCCS and Advanced Care Planning (ACP) in extending to other conditions (LTC and dementia) (April 2015)

Objective: To reduce the variation in care for patients with cardiovascular disease (Outcome Domain 3)
Transformational programme that consolidates acute cardiovascular expertise in a reduced number of emergency care centres (Hub & Spoke)

Delivered through a programme on improving health outcomes through standardising acute models of cardiovascular care and reducing unwarranted variation

- SEC-wide agreed service specification for 6-month review for stroke survivors (Sept 2014)
- Baseline mapping of invasive cardiology services including heart attack pathways and sustainable cases for change developed (July 2014)
- Acute stroke pathway reviews across SEC and support for cases for change (April 2015)
- Cases for change for other acute cardiovascular services, e.g. complex cardiology and renal services (2014-16)
- Development of guidance on AKI care bundles for secondary care (April 2015)
- Best Practice framework for life after stroke (2014)
- Framework for provision of generic and integrated rehabilitation services and skills (2016)
- Consolidating acute cardiovascular expertise in a reduced number of emergency care centres (hub and spoke) (2018)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- CVD programmes and improvement interventions overseen by SEC SCN CVD Steering Group
- Project task and finish groups overseen by multi-stakeholder Clinical Advisory Groups (cardiac, renal, stroke & diabetes) and commissioner forums

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care delivery and quality, identified in 2013 baseline reviews

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation

Strategic Clinical Network: Maternity, Children and Young People

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved Maternity, Children & Young People (MCYP) healthcare outcomes across Kent, Surrey and Sussex. Improved patient experience and safety underpin all our work programmes

Objective: To reduce perinatal mortality and morbidity (Outcome Domain 1)

Delivered through a programme on reducing perinatal mortality and morbidity

- Agreed best practice pathway and associated case for change for pre-term birth (March 2015)
- Agreed model of care to support prevention of stillbirth (2015-16)

Objective: To reduce inappropriate paediatric attendances and admissions to secondary care (Outcome Domain 2)
Transformational programme that increases capability in community services

Delivered through a programme on moving the clinical care of children & young people from secondary to community and primary care settings (NHS at Home)

- Agreed Children's Community nursing service model and service specification (2015)
- Agreed models of care and smooth transition pathways from childhood to adult services for children and young people with diabetes, epilepsy and asthma (2015-16)
- Review of all transition areas which require specific focus, including end of life care services (September 2014)
- Encourage adoption of EPaCCS across children's end of life care services (April 2015)
- Production of slide set/report with a visual guide and narrative explaining who commissions what across the CCG, Direct, Specialised and Joint commissioning system for CYP services (2014)

Objective: To promote high quality maternity care and experience

Delivered through a programme on high quality maternity care and experience

- Agreed maternity service standards across SEC (March 2014)
- Developed and agreed maternity key performance indicators (September 2014)
- Agreed maternity dashboard that supports both providers and commissioners (September 2014)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- MCYP programmes and improvement interventions overseen by SEC MCYP SCN Steering Group
- Project task and finish groups overseen by multi-stakeholder Clinical Advisory Groups (maternity, children and young people, transition) and commissioner forums

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care delivery and quality, identified in 2013 baseline reviews

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation

Strategic Clinical Network: Mental Health, Dementia and Neurological Conditions

A network of patients, carers, the public, clinicians and commissioners who have come together to agree, refine and implement improved Mental Health, Dementia and Neurological Conditions (MHDN) healthcare outcomes across Kent, Surrey and Sussex.
Improved patient experience and safety underpin all our work programmes

Objective: Development of acute access to mental health and neurological specialist (Outcome Domain 1)

Delivered through rapid access to specialist care for people with mental health and neurological acute conditions

- Audit of psychiatric liaison and crisis intervention teams (July 2014)
- Baseline of emergency attendance in neurology (May 2014)
- Case for change for emergency crisis intervention in psychiatry (Sept 2014)
- Agreed emergency model of neurology acute assessment (March 2015)
- Case for change for the innovative 'networked' model of acute neurology assessment (September 2015)
- Agreed model of emergency mental health access (April 2016)
- Solution for Section 136 issues for children and young people (Sept 2014)

Objective: Development of clear pathways for those with long term neurological conditions – Parkinson's Disease, Multiple Sclerosis, Motor Neurone Disease and Epilepsy
(Outcome Domain 2)

Delivered through development of clear and navigable pathways

- Baseline of current activity and spend on neurological LTCs (May 2014)
- Future LTC pathway described (October 2014)
- Mapping of neurology services (November 2014)
- Case for change for alignment of LTC pathways 'moving investment around' (June 2015)
- New pathways commissioned (December 2015)
- Improvement of ACP and extension of EPaCCS to include LTC care plans (April 2017)

Objective: Timely diagnosis of dementia with immediate post-diagnosis support and long-term self-management (Outcome Domain 2)
Transformational programme that increases Primary Care capacity

Delivered through moving more dementia diagnostics into primary care and improving long-term care of dementia

- Describe primary care diagnostic model (May 2014)
- Develop a case for change for moving diagnostics (September 2014)
- Describe a model of post-diagnostic support (September 2014)
- Describe a networked 'admission avoidance' plan which can be used by commissioners (September 2016)
- Improvement of ACP and extension of EPaCCS to include dementia care plans (April 2017)

Objective: Fully integrated model of care for children and young people accessing mental health service (Outcome Domain 3)
Transformational programme that achieves large-scale integration

Delivered through development of clear and navigable pathways

- Model of integrated system developed and published in line with NHS England guidance and priorities (March 2015)
- Case for change for acceptance by CCGs and HWBs (September 2015)
- New pathways commissioned (April 2016)

Overseen through the following governance arrangements

- Shared system leadership Oversight Group overseeing implementation of all SCN programmes
- MHDN programmes and improvement interventions overseen by MHDN Steering Group
- Project task and finish groups overseen by Clinical Advisory Groups, patient and public and commissioner forums

Measured using the following success criteria

- Supports sustainable and affordable services
- Delivery of the outcomes framework
- Reduction in unwarranted variations of care delivery and quality, identified in 2013 baseline reviews

System values and principles

- We seek improvement through clinical leadership, strategic focus and large-scale change and transformation
- We will maximise value by seeking the best outcomes for every pound invested
- We put the public and clinical voice central to all we do
- We will align and collaborate with strategic partners such as AHSN and HEE
- We embrace innovation
- We will contribute towards delivering NHS England's commitment to 'parity of esteem'