Planning for tomorrow, delivering today

Operating Plan 2015/16 summary

This summary plan gives an overview of our work programme for 2015/6. Our operational plan is intended to make sure that what we set out to do is realistic and achievable, given the resources we have.

The plan sets out how we will focus on delivering a number of foundation projects for mental health, long-term conditions, urgent care, and planned care aligned to Health and Well Being Board priorities. It also sets out how we will work with our providers to meet NHS Constitution standards and what we will do to deliver harm free, high quality care in a financially sustainable way.

Key to the delivery of our plans will be Commissioning for Value, a collaboration between NHS Right Care, NHS England and Public Health England. This will enable us identify real opportunities to improve outcomes and increase value for local populations. It will also help us to prioritise areas for change, better utilise resources and make improvements in healthcare quality, outcomes and efficiency.

Aligning local plans to Health and Well Being Board priorities and national outcomes

		National Outcome Indicators			Health and Wellbing Strategy Outcomes	Local Priorities				
		Seven Outcome Ambitions	Strategic Risks	Measures		Community Network	Commissioning for Value	Parity of Esteem	Urgent Care	Primary Care
Effectiveness	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.	✔	✔	✔	✔	✔	✔
Experience	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	✔	✔	✔	✔	✔	✔
Safety	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	✔	✔	✔	✔	✔	✔
Accountability	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	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)		✔	✔	✔	✔	✔

Commissioning priorities for the year ahead

The priorities set out in our 2014/19 Strategic Commissioning Plan 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.

2014/15

Our commissioning projects were designed to put the foundations in place, allowing for stabilisation during 2015/16 and significant transformational change during 2016/17, supporting people to look after themselves within their local community.

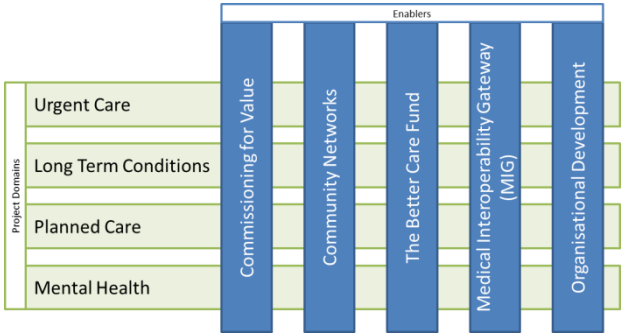
To this end a number of projects have been delivered during the first year of our plan. Examples of these are:

- ***Long Term Conditions***
  - Community Networks have been set up
  - Increased our dementia diagnosis rates
  - Our care homes projects have led to a reduction in urgent care attendances and admissions
- ***Mental Health***
  - Primary Care base mental health workers are now in place
  - Significant progress in increasing recovery rates with our IAPT services whilst also reducing waiting times.
- ***Urgent Care***
  - New integrated discharge teams
  - Reduced delays in having care packages in place for timely discharge following inpatient care
  - Local Referral Unit ensures that patients are offered support within their own homes
  - Trialled weekend opening for general practices

2015/16

The CCGs have recognised that in previous years we have attempted to effect change across too many fronts and have subsequently not have sufficient capacity to deliver the goals we have set ourselves.

Commissioning for Value is a collaboration between NHS Right Care, NHS England and Public Health England. The programme is about identifying priority programmes which offer the best opportunities to improve healthcare for our populations – improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system. As a consequence of this approach, we are able to focus the work of its limited commissioners on areas that will generate best outcome clinically and financially.



Commissioning for Quality and safety

Patients and the quality and safety of care they receive continues to be the focus of all that we do. By ensuring that quality improvement is integral to our future strategy as well as the CCGs vital assurance role, we are able to commission clinical services which provide high quality care, the best outcomes for patients and a positive patient experience.

Commissioning projects 2015/16

	Anticpated Outcome	Constitutional Standard	M	J	J	A	S	O	N	D	J	F	M	2016-17
Urgent Care														
– Integrated Urgent Care Centre	Reduction in A&E Attendances	A&E												
– Seven Day Primary Care	Reduction in A&E Attendances	5YFV												
– Minor Injuries Units	Reduction in A&E Attendances	A&E												
– Care Homes Support	Reduction in Non-Elective Admissions	Better Care Fund												
– Paramedic Practitioner	Reduction in Non-Elective Admissions	A&E												
– NHS 111 Procurement														
Planned Care														
– Orthopaedics Triage Service	Reduction in referrals and procedures	RTT												
– Rheumatology	Reduction in referrals	RTT												
– Personal Decision Aids	Reduction in referrals and procedures	RTT												
– Dermatology	Reduction in referrals	RTT												
– Wet Age-Related Macular Degeneration	Reduced cost of treatment													
– Falls Prevention and Treatment		Better Care Fund												
– Community Loan Store	Earlier discharge from inpatient episode													
– Community DVT Service														
– Anti-Coagulation Service														
– Breast Cancer														
Mental Health														
– Care Programme Approach	Reduce admissions, increased employment	NHS Right Care												
– IAPT Procurement		NHS Right Care												
Long Term Conditions														
– Cardiology	Earlier identification, Reduced non-elective admissions	NHS Right Care												
– Chronic Kidney Disease	Earlier identification, Reduced non-elective admissions	NHS Right Care												
– Diabetes	Community based care													
– End of Life Care	Community based care													
– Neurology		NHS Right Care												
– Stroke		NHS Right Care												
– Dementia	Earlier diagnosis	5YFV												
– Age UK														
– Reducing Community Nursing Demand	Increase capacity													
Child Health and Maternity														
– Children's Strategy														

Health Reform Group - New Cases

Health Reform Group - Post Implementation Review

Review of 2014/15: NHS Constitution Standards

Referral To Treatment waiting times for non-urgent consultant-led treatment	Target	2014/15	Commentary
Admitted patients to start treatment within a maximum of 18 weeks from referral	90.00%	Underachieving	EKHUFT has failed to achieve the national referral to treatment standard this year. A recovery plan was agreed with the Trust, including action by the east Kent CCGs to reduce referral rates in T&O, to achieve compliance by April 2015. This plan failed due to the following factors: Lack of uptake in the independant secto; staff sickness; increasing numbers of cancer referrals, and consultant compliance to pathways ie spinal. A revised plan returning the trust to RTT complaince by October 2015 has been received by CCGs and the activity that undpins it is included in 2015/16 activity plans and contractual values. The CCGs support this more realistic (given the scale of the backlog and previous deleivery performance) trajectory. We will, however, be seeking further assurance on the 12 assumptions that support the delievery of EKHUFT's plan, many of which relate to acute sector capacity.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95.00%	Achieving	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92.00%	Achieving	

Diagnostic test waiting times	Target	2014/15	Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99.00%	Achieving	Recruitment to key posts have meant that this standard underachieved in Q1,2 & 3 through a robust action plan and recruitment campaign performance improved in December 2014 and remains compliant.

A&E waits	Target	2014/15	Commentary
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95.00%	Underachieving	While A&E attendance levels have remained broadly flat waiting time performance steadily worsened during 2014/15 with the EKHUFT failing the standard, despite an investment of £8m in east kent with the majoriy of this resource deployed to the acute trust. A system wide improvement plan was agreed in January 2015 and at the same time the CCGs in east Kent revised and strenghtened governance and performance management arrangements. Plans have been monitored weekly against agreed recovery trajectory with bi weekly senior operational leadership review. Due to ongoing failure of this standard CCGs issued EKHUFT with a contract query notice in March 2015. A new 'Emergency Access Recovery Plan' has been submitted to the CCGs by EKHUFT. EKHUFT have invited Emergency Care Intensive Support Team into Trust on 13-15 May to underatake a full diagnostic of both the flow of patients through A&E and a review of all patients with a LOS greater than 7 days. CCGs will continue to work with the Trust and health economy partners on a sustainable plan to achieve this standard by the end of Quarter 2 2015 - this will include individual provider plans which will underpin the system wide improvement plan. Compliance of this standard by October 2015 is contingent on the findings of the ECIST report.

Cancer waits – 2 week wait	Target	2014/15	Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93.00%	Achieving	Achievement of cancer targets has been variable throughout 2014/15, with the majority of challenges arising in 2 week waits for first appointment, and 31 day wait for subsequent surgery. The overall target of 62 days from referral to first treatment was challenging throughout the year, but has shown improvement and recovered performance to standard through the production of a trust wide action plan which led to a revised referral form for GPs to follow for 2 week breast cancer patients and trust wide changes to diagnostic support and workforce. EKHUFT has made significant improvements to booking procedure allowing the service to recover its position in part although GP refferals remain high along delays on complex pathways, taking longer to diagnosis primary cancer and therefore initiate treatment. The standard is now being monitored through a senior cancer group to ensure these standards are met through the robust monitoring of a revised cancer plan.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93.00%	Underachieving	

Review of 2014/15: NHS Constitution Standards

Category A ambulance calls	Target	2014/15	Commentary
Category A calls resulting in an emergency response arriving within 8 minutes	75.00%	Achieving	Achievement of the national targets for ambulance response times has been variable throughout the year. Recruitment of additional paramedics has been initiated in 2014/15, with plan s in 2015/16 to train additional paramedic practitioners. Development of an improved integrated local first responders team is planned for 2015/16.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95.00%	Achieving	

Mental Health	Target	2014/15	Commentary
Dementia - % diagnosis rate	66.70%	Underachieving	The CCG aims to improve the identification and care for patients with Dementia from 62.2% as at February 2015 to 66.7% by the first quarter of 2015/16. Throughout 2014/15 actions have been taken to increase the number of patients identified as having dementia in all GP practices, including data cleansing and programmes of training and support for practices to sign post and support patients following diagnosis and additional GP support to enable the identification of dementia patients.The reported position for the end of Feb 15 was 62.2% of patients identified in C&C and 49.91% for Ashford. Practice engagement remains the challenge in Ashford with plans to achieve this standard by Q2 2015/16 with C&C expected to meet the standard by Q1 of 2015/16. CCG clinical chairs will continue to work with practices to ensure all of the necessary support is in place to enable compliance.
Inpatient Follow-up - within 7 days after discharge from in-patient care	95.00%	Achieving	Exception reports for non-compliance are reviewed through contract meetings.
IAPT - access proportion	15.00%	Achieving	The CCG continues to exceed the target rate for access to psychological therapies. Targets for recovery rates are met for 2014/15.
IAPT - Recovery Rate	50.00%	Achieving	
IAPT - Treatment within 6wks of referral	75.00%	N/A	New target for 2015/16
IAPT - Treatment within 18wks of referral	95.00%	N/A	New target for 2015/16
Psychosis - Treatment within 2wks	50.00%	N/A	New target for 2015/16

Delivering harm free, high quality care in a financially sustainable way

The CCGs received a reduced allocation from the autumn statement, 1.4%, with growth per capita below 1% and some of the lowest in the country. In 2015/16 the main challenge and risk concerns delivery of planned benefits from Quality, Innovation, Productivity and Prevention (QIPP) schemes to fund the pressures above the funding growth.

NHS Ashford CCG

The plan balances in year, maintaining the 2014/15 surplus. However, it does not return the CCG to a 1% surplus within 15/16. A recovery plan has been submitted to NHS England in line with planning guidance. The plan details the actions being taken to address the longer term financial position of the CCG utilising the NHS Right Care approach to deliver value in commissioning.

NHS Canterbury and Coastal CCG

The plan delivers a 1% surplus, but assumes return of surplus from 2014/15 to fund some non recurrent investments in Mental Health, Community Networks (MCP development) and the NHS Right Care program.

Activity

The contract with the main acute providers are being planned at the previous years contract out turn levels with the exception of areas where additional activity is needed to achieve constitutional targets. The CCGs have implemented referral management services and non elective changes that will maintain the activity at these levels. Further QIPP/Commissioning for Value savings are required to reduce the contracts below 14/15 out turn to fund pressures in CHC, prescribing and national initiatives such as parity of esteem. The main activity reductions are within urgent care, with an expected reduction of between 2-3 admissions per site per day.

QIPP/Commissioning for Value

Through revision of the planning and contract discussions with providers the QIPP target has been reduced to 2% for Canterbury and 3.1% for Ashford. The main schemes are :

- Continuation, and expansion to other specialities, of the orthopaedic triage and management process
- Reduction in HCD expenditure through use of best practice and potential drug alternative s such as bio similar products
- Roll out of the successful winter schemes and implementation of IUCC to reduce unscheduled care admissions
- Review of community nursing staff provision and OOH services
- Securing better value in CHC placements through market and process management
- Review of products supplied to care homes
- Continued implementation of the NHS Right Care programme

Quality and Safety Plans 2015/2016

The Quality and Safety team covering NHS Ashford CCG and NHS Canterbury and Coastal CCG will continue to develop a quality approach that is influenced by three national reports, The Winterbourne report, The Berwick report and the Francis report. The CCGs five year plan outlines this approach in further detail.

The CCG will continue to work with commissioned providers to gain assurance in relation to the quality and safety of services and outcomes. This is to be strengthened in 2015/2016 via improved schedule four quality metrics focussing on year on year improvement.

The CCG will act as the link across providers to drive service improvement, patient safety and patient experience. Collaborative local CQUINs are being put into place for 2015/2016 across both the acute and community providers to ensure that whole system pathways in relation to heart failure, diabetes, COPD and the frail elderly are developed and implemented. These are central to our strategic approach to deliver quality related improvement at a reduced spend.

The CCG is committed to ensuring safe clinical services and will be working with commissioned providers and the local health and social care economy to ensure that the actions required by the Care Act 2015 are fully embedded within our own and commissioned organisations. This focus also includes the actions relating to the national PREVENT agenda.

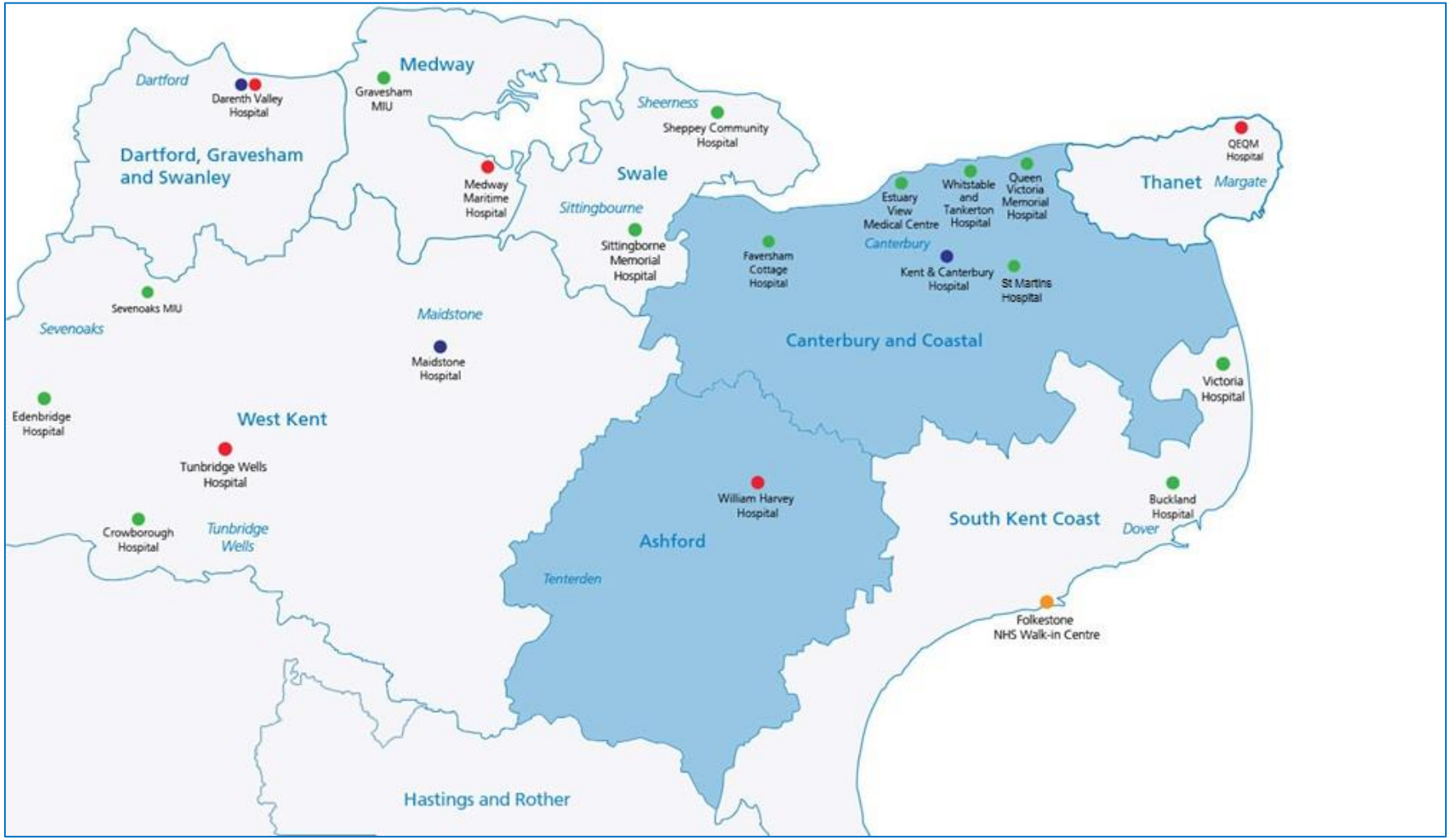
The CCG plans for 2015/2016 include further improvements in the reduction of healthcare associated infections as well as maintaining the zero case MRSA achievement made in 2014/2015.

The CCG plan to continue to work with care homes within the locality in order to improve the quality of care provided. This work supports the longer commissioning strategy within the CCG five year plan.

Planning for Tomorrow, Delivering Today

Strategic Commissioning Plan 2014 - 2019

Contents


Dartford
Darenth Valley Hospital
Dartford, Gravesham and Swanley
Medway
Gravesham MIU
Medway Maritime Hospital
Sheerness
Sheppey Community Hospital
Swale
Sittingbourne
Sittingborne Memorial Hospital
Sevenoaks MIU
Sevenoaks
Maidstone
Maidstone Hospital
Edenbridge Hospital
West Kent
Tunbridge Wells Hospital
Crowborough Hospital
Tunbridge Wells
Faversham Cottage Hospital
Canterbury
Estuary View Medical Centre
Whitstable and Tankerton Hospital
Queen Victoria Memorial Hospital
Kent & Canterbury Hospital
St Martins Hospital
Canterbury and Coastal
QEQM Hospital
Thanet
Margate
Victoria Hospital
William Harvey Hospital
Ashford
Tenterden
South Kent Coast
Buckland Hospital
Dover
Folkestone NHS Walk-in Centre
Hastings and Rother

Introduction

In our five year Strategic Commissioning Plan, both NHS Ashford CCG and NHS Canterbury CCG stated an intention to merge into a single CCG. Whilst this will not now proceed, and CCGs retain their individuality in statutory responsibilities, our planning assumptions continue to reflect the fact that both our patient demographics and needs are very similar.

This plan gives an overview of our work programme for 2015/6. Our operational plan is intended to make sure that what we set out to do is realistic and achievable, given the resources we have. The plan sets out how we will focus on delivering a number of foundation projects for mental health, long-term conditions, urgent care, and planned care aligned to Health and Well Being Board priorities. It also sets out how we will work with our providers to meet NHS Constitution standards and what we will do to deliver harm free, high quality care in a financially sustainable way.

Key to the delivery of our plans will be Commissioning for Value, a collaboration between NHS Right Care, NHS England and Public Health England. This will enable us identify real opportunities to improve outcomes and increase value for local populations. It will also help us to prioritise areas for change, better utilise resources and make improvements in healthcare quality, outcomes and efficiency.

NHS Ashford CCG covers the town of Ashford as well as surrounding rural areas, including Tenterden, Wye and Charing.

The CCG is made up of the 15 general practices (doctors' surgeries) in the Ashford area. The CCG is co-terminus with Ashford Borough Council.

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.

NHS Ashford CCG	Data
Registered patient population:	122,000
Number of GP practices:	15

NHS Canterbury and Coastal CCG covers the City of Canterbury, the towns of Faversham, Whitstable, Herne Bay, Sandwich & Ash as well as surrounding rural areas.

There are 21 practices in Canterbury and Coastal, 15 of which are located in Canterbury City Council area. Three practices are located in within Swale Borough Council area and the other three practices are located in the Dover District Council area. There is also a branch practice located in Chilham which is in the Ashford Borough Council area.

The CCG has an annual budget of £239 million to deliver healthcare services for the 211,651 people registered with a GP surgeries in the Canterbury and Coastal area. That equates to around £1,130 per person.

NHS Canterbury and Coastal CCG	Data
Registered patient population:	211,651
Number of GP practices:	21

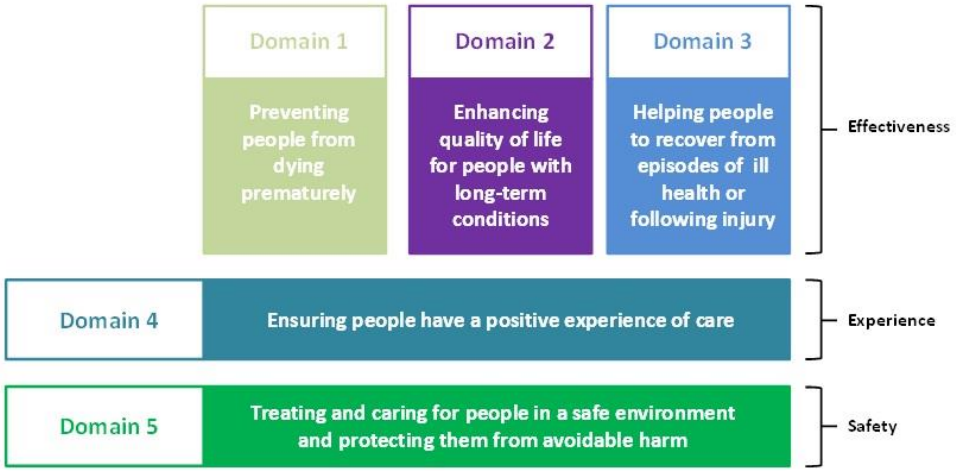
Moving Forward: The National Context

Our vision and goals within our plan have not been developed in isolation and reflect the broader strategic context in which we operate as statutory bodies. 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 domains.

"Five Year Forward View" identifies that, in order to meet patients' needs and expectations, we need to develop a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction that the NHS should taking:

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

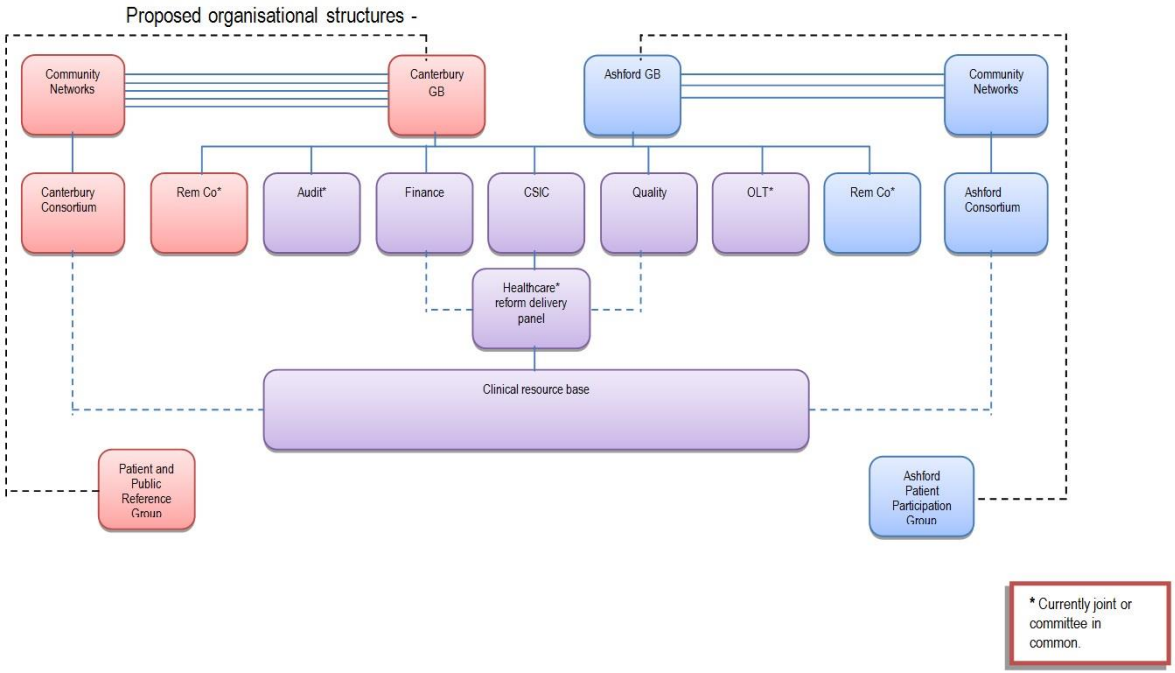
For both NHS Ashford and NHS Canterbury & Coastal CCGs this approach is supported through our Community Networks programme which will offer accessible and responsive services that extend well beyond what is currently available in general practices.



	National Ambition
1	Securing additional years of life for the people of England with treatable mental and physical health conditions.
2	Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
3	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4	Increasing the proportion of older people living independently at home following discharge from hospital.
5	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
6	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.
7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Both CCGs work closely with all Kent and Medway CCGs to ensure alignment of plans and agree how any variances or misalignments are resolved. There is a significant amount of work being undertaken with our main providers (EKHUFT, KCHT, KMPT) as well as social care to achieve alignment of plans and clinical strategies to deliver new models of integrated care. Key examples include the development of the MCP model at Estuary View which is a national vanguard site, the learning from which will be rolled out to other areas wherever practicable.

Our GP members meet every other months throughout the year and are actively engaged in developing the CCG Plan. The Governing Body regularly reviews the delivery of the CCG Plan, hearing from the Lay Member about public and patient engagement, considers the performance of its key providers, and reviews the financial position of the CCG. The Clinical Strategy and Investment Committee clinical leadership for the delivery of the CCG Plan and clinically based strategic direction and oversight.



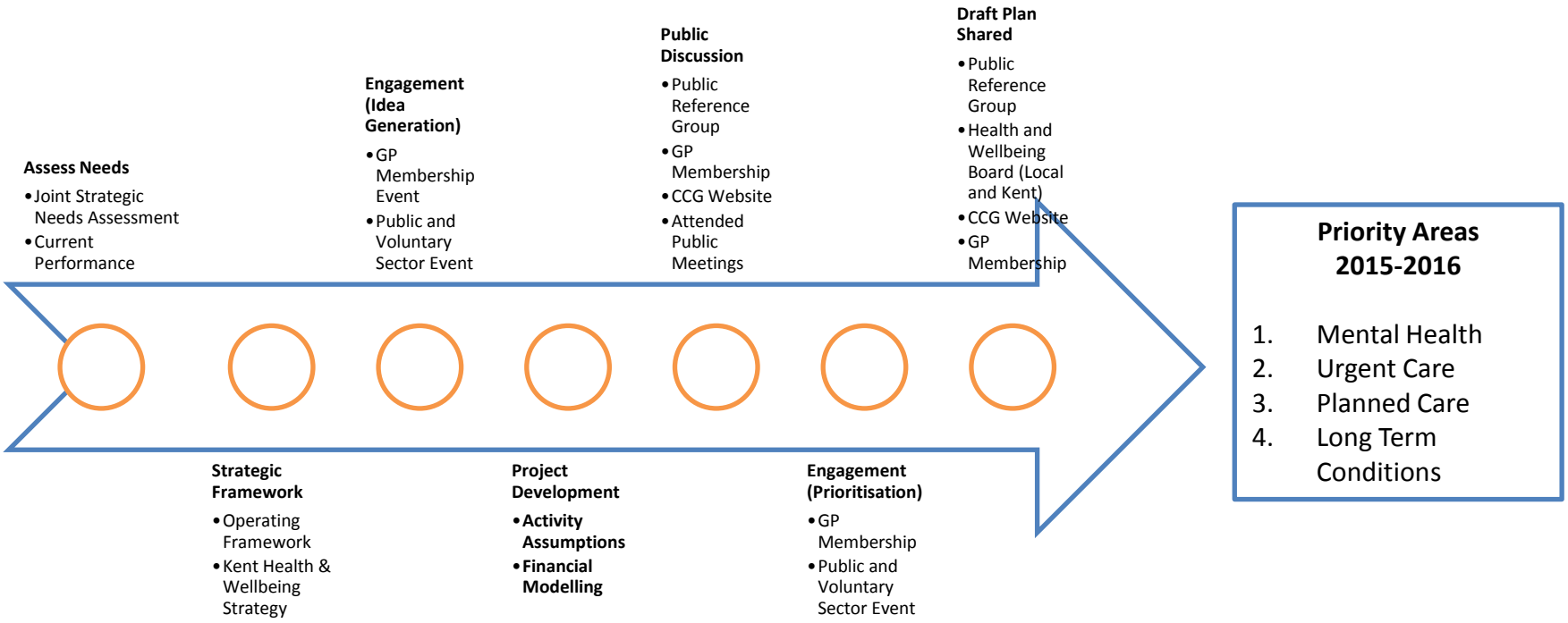
Monitoring the performance of the providers is a key responsibility of the Governing Body. A detailed review of quality and performance takes place at the Quality and Safety Committee whilst the Audit and Risk Committee has responsibility for audit and for providing assurance to the Governing Body that the systems and processes which the CCG has in place are working well. The CCG cannot deliver its ambitions on its own. We work in partnership, particularly with our District Councils and all members of our local and county Health and Wellbeing Boards.

We are currently reviewing the governance arrangement for those areas of federated commissioning across east Kent, developing risk and assurance platform to incorporate performance and strategic risks across providers and commissioners

This Strategic Commissioning Plan and the component projects, which we set out last year, were the product of our ambition to continually improve the quality and patient experience of local health care services. They built on our experience and robust information and analysis and developed in partnership with key partners including Social Care, local Government, our patients, carers and Public Health colleagues.

During the course of the Plan's development we engaged our member practices, exploring local needs and inequalities (supported by Public Health). We 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.

Another key element in the Plan's development were Health and Wellbeing Boards who both contributed to and 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.



Strategic Objectives, Aims and Risks

		National Outcome Indicators			Health and Wellbing Strategy Outcomes	Local Priorities				
		Seven Outcome Ambitions	Strategic Risks	Measures		Community Network	Commissioning for Value	Parity of Esteem	Urgent Care	Primary Care
Effectiveness	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.	✔	✔	✔	✔	✔	✔
Experience	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	✔	✔	✔	✔	✔	✔
Safety	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	✔	✔	✔	✔	✔	✔
Accountability	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	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)		✔	✔	✔	✔	✔

Overall responsibility for quality lies with the CCG Governing Bodies, 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.

Our Governing Bodies aim 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

Both CCGs will, through our 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

Both CCGs 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

Both CCGs 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 the CCGs and we will continue 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

Care Quality Commission

Across east Kent we pride ourselves on commissioning and providing excellent care for our patients. When we fail to live up to our own high standards, we look to rectify the position. During 2014-15, local providers have been assessed by the CQC and as a consequence have introduced actions plans to address shortfalls in performance.

East Kent Hospitals

The action plan resulting from the inspection is focussed on recruitment and retention of clinical staff, ensuring policies are up-to-date and communicated widely with staff, that the environment and equipment used for treatment is maintained to a high standard, waiting times for treatment are reduced and that reporting structures for incidents and risks are refined.

Kent Community Health

The action plan resulting from the inspection is focussed on end of life care, children's services, recruitment and staff retention, care planning and that the environment and equipment used for treatment is maintained to a high standard.

We continue to monitor progress against both of these action pans.

Management of Serious Incidents (SI) and Never Events

All Serious Incidents and never events are reviewed and discussed by the quality committee.

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.

Healthcare Associated 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.

The First Year

2014-2015: Progress to Date

The priorities set out in our 2014/19 Strategic Commissioning Plan 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.

2014/15

Our commissioning projects were designed to put the foundations in place, allowing for stabilisation during 2015/16 and significant transformational change during 2016/17, supporting people to look after themselves within their local community.

To this end a number of projects have been delivered during the first year of our plan. Examples of these are:

- ***Long Term Conditions***
  - Community Networks have been set up
  - Increased our dementia diagnosis rates
  - Our care homes projects have led to a reduction in urgent care attendances and admissions

- ***Mental Health***
  - Primary Care base mental health workers are now in place
  - Significant progress in increasing recovery rates with our IAPT services whilst also reducing waiting times.

- ***Urgent Care***
  - New integrated discharge teams
  - Reduced delays in having care packages in place for timely discharge following inpatient care
  - Local Referral Unit ensures that patients are offered support within their own homes
  - Trialled weekend opening for general practices

Review of 2014/15: NHS Constitution Standards

Referral To Treatment waiting times for non-urgent consultant-led treatment	Target	2014/15	Commentary
Admitted patients to start treatment within a maximum of 18 weeks from referral	90.00%	Underachieving	EKHUFT has failed to achieve the national referral to treatment standard this year. A recovery plan was agreed with the Trust, including action by the east Kent CCGs to reduce referral rates in T&O, to achieve compliance by April 2015. This plan failed due to the following factors: Lack of uptake in the independant secto; staff sickness; increasing numbers of cancer referrals, and consultant compliance to pathways ie spinal. A revised plan returning the trust to RTT complaince by October 2015 has been received by CCGs and the activity that undpins it is included in 2015/16 activity plans and contractual values. The CCGs support this more realistic (given the scale of the backlog and previous deleivery performance) trajectory. We will, however, be seeking further assurance on the 12 assumptions that support the delievery of EKHUFT's plan, many of which relate to acute sector capacity.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95.00%	Achieving	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92.00%	Achieving	

Diagnostic test waiting times	Target	2014/15	Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99.00%	Achieving	Recruitment to key posts have meant that this standard underachieved in Q1,2 & 3 through a robust action plan and recruitment campaign performance improved in December 2014 and remains compliant.

A&E waits	Target	2014/15	Commentary
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95.00%	Underachieving	While A&E attendance levels have remained broadly flat waiting time performance steadily worsened during 2014/15 with the EKHUFT failing the standard, despite an investment of £8m in east kent with the majoriy of this resource deployed to the acute trust. A system wide improvement plan was agreed in January 2015 and at the same time the CCGs in east Kent revised and strenghtened governance and performance management arrangements. Plans have been monitored weekly against agreed recovery trajectory with bi weekly senior operational leadership review. Due to ongoing failure of this standard CCGs issued EKHUFT with a contract query notice in March 2015. A new 'Emergency Access Recovery Plan' has been submitted to the CCGs by EKHUFT. EKHUFT have invited Emergency Care Intensive Support Team into Trust on 13-15 May to underatake a full diagnostic of both the flow of patients through A&E and a review of all patients with a LOS greater than 7 days. CCGs will continue to work with the Trust and health economy partners on a sustainable plan to achieve this standard by the end of Quarter 2 2015 - this will include individual provider plans which will underpin the system wide improvement plan. Compliance of this standard by October 2015 is contingent on the findings of the ECIST report.

Cancer waits – 2 week wait	Target	2014/15	Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93.00%	Achieving	Achievement of cancer targets has been variable throughout 2014/15, with the majority of challenges arising in 2 week waits for first appointment, and 31 day wait for subsequent surgery. The overall target of 62 days from referral to first treatment was challenging throughout the year, but has shown improvement and recovered performance to standard through the production of a trust wide action plan which led to a revised referral form for GPs to follow for 2 week breast cancer patients and trust wide changes to diagnostic support and workforce. EKHUFT has made significant improvements to booking procedure allowing the service to recover its position in part although GP refferals remain high along delays on complex pathways, taking longer to diagnosis primary cancer and therefore initiate treatment. The standard is now being monitored through a senior cancer group to ensure these standards are met through the robust monitoring of a revised cancer plan.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93.00%	Underachieving	

Category A ambulance calls	Target	2014/15	Commentary
Category A calls resulting in an emergency response arriving within 8 minutes	75.00%	Achieving	Achievement of the national targets for ambulance response times has been variable throughout the year. Recruitment of additional paramedics has been initiated in 2014/15, with plan s in 2015/16 to train additional paramedic practitioners. Development of an improved integrated local first responders team is planned for 2015/16.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95.00%	Achieving	

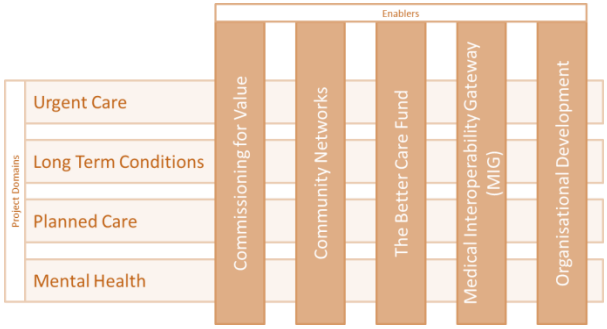
Mental Health	Target	2014/15	Commentary
Dementia - % diagnosis rate	66.70%	Underachieving	The CCG aims to improve the identification and care for patients with Dementia from 62.2% as at February 2015 to 66.7% by the first quarter of 2015/16. Throughout 2014/15 actions have been taken to increase the number of patients identified as having dementia in all GP practices, including data cleansing and programmes of training and support for practices to sign post and support patients following diagnosis and additional GP support to enable the identification of dementia patients.The reported position for the end of Feb 15 was 62.2% of patients identified in C&C and 49.91% for Ashford. Practice engagement remains the challenge in Ashford with plans to achieve this standard by Q2 2015/16 with C&C expected to meet the standard by Q1 of 2015/16. CCG clinical chairs will continue to work with practices to ensure all of the necessary support is in place to enable compliance.
Inpatient Follow-up - within 7 days after discharge from in-patient care	95.00%	Achieving	Exception reports for non-compliance are reviewed through contract meetings.
IAPT - access proportion	15.00%	Achieving	The CCG continues to exceed the target rate for access to psychological therapies. Targets for recovery rates are met for 2014/15.
IAPT - Recovery Rate	50.00%	Achieving	
IAPT - Treatment within 6wks of referral	75.00%	N/A	New target for 2015/16
IAPT - Treatment within 18wks of referral	95.00%	N/A	New target for 2015/16
Psychosis - Treatment within 2wks	50.00%	N/A	New target for 2015/16

The Second Year…

2015 – 2016: Operating Plan

The CCGs have recognised that in previous years we have attempted to effect change across too many fronts and have subsequently not have sufficient capacity to deliver the goals we have set ourselves.

Commissioning for Value is a collaboration between NHS Right Care, NHS England and Public Health England. The programme is about identifying priority programmes which offer the best opportunities to improve healthcare for our populations – improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system. As a consequence of this approach, we are able to focus the work of its limited commissioners on areas that will generate best outcome clinically and financially.



Commissioning for Quality and safety

Patients and the quality and safety of care they receive continues to be the focus of all that we do. By ensuring that quality improvement is integral to our future strategy as well as the CCGs vital assurance role, we are able to commission clinical services which provide high quality care, the best outcomes for patients and a positive patient experience.

Contracting

The CCG will work to further integrate Health and Social Care services through delivery of the Better Care Fund (BCF). This programme will be the vehicle by which the local system, through early identification of deterioration, will achieve reductions in A&E attendance and subsequent admission and premature admissions to long term care.

The CCG will negotiate a 2015/16 contract with East Kent Hospitals University Foundation Trust (EKHUFT) that provides financial security to both the Trust and the CCG, by limiting the reliance upon activity counting and unit prices. This will reduce bureaucracy and allow focus on improving patient services and delivering value for money.

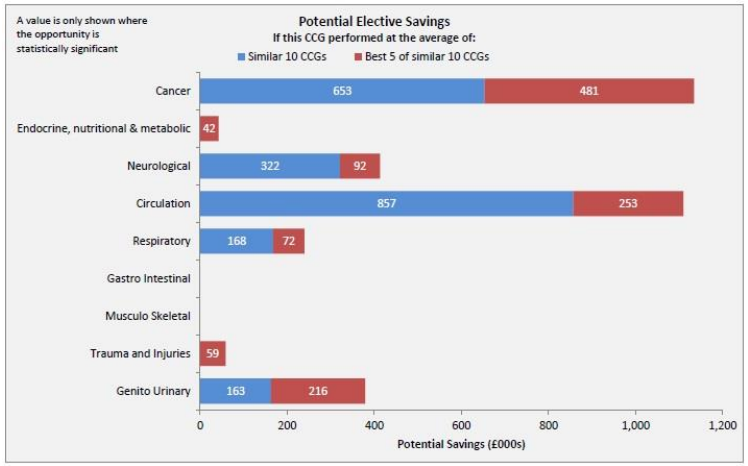
The CCG will ensure that parity of esteem for mental health patients is captured within all contracts for 2015/16.

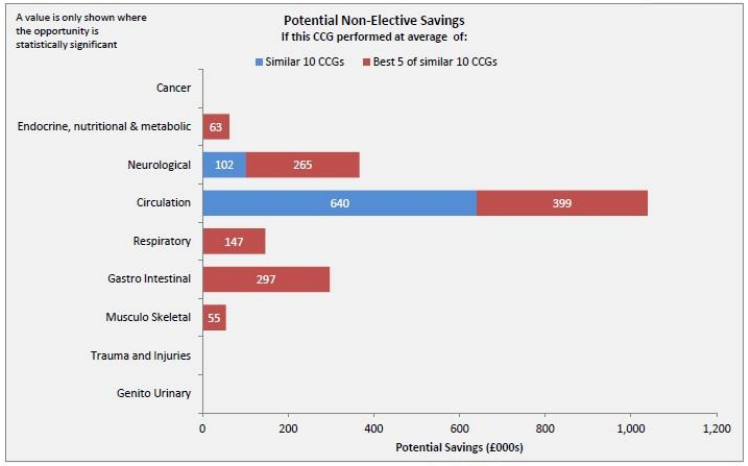
The CCG will continue to develop the Local Health Economy (LHE) Workforce, including a Health and Social Care Apprenticeship Programme, to ensure 'right care' by the 'right person' at the 'right time', to provide clinical leadership and support recruitment and retention. All with the intention of supporting delivery of our transformative plans for new models of care.

The CCG will develop system integration via the Medical Interoperability Gateway (M.I.G) where access to the patient GP record (with patient consent) will be visible across multiple providers to avoid duplication and improving care for patients by enabling them to tell 'us once'.

CQUINs will be targeted towards incentivising a continued focus on patients aged over 75, to compliment the named GP policy incentivised as part of change to GP contracts from April 2015. CQUINs of all major providers will be tailored towards adding capacity and capability to our, already successful, neighbourhood teams which currently bring together GPs, Social Services and Community Services to deliver improved outcomes for all residents.

Enabler: Commissioning For Value





The CCGs have 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.

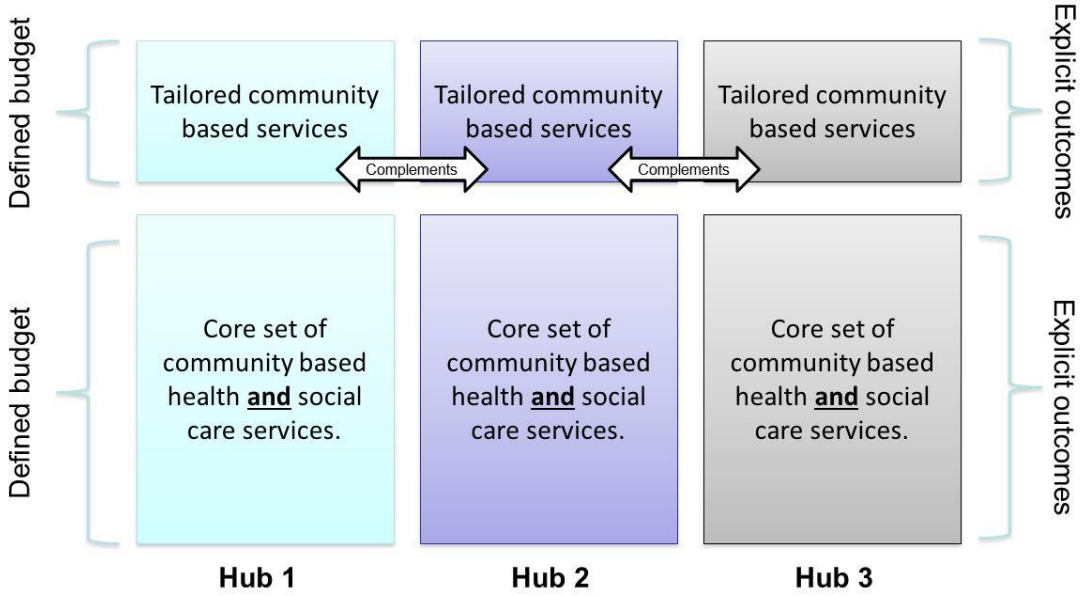
The programme areas that appear to offer the greatest opportunity in terms of financial savings are: Cancer, Circulation problems (CVD) and Neurological System Problems.

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.

Enabler: Community Networks

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:

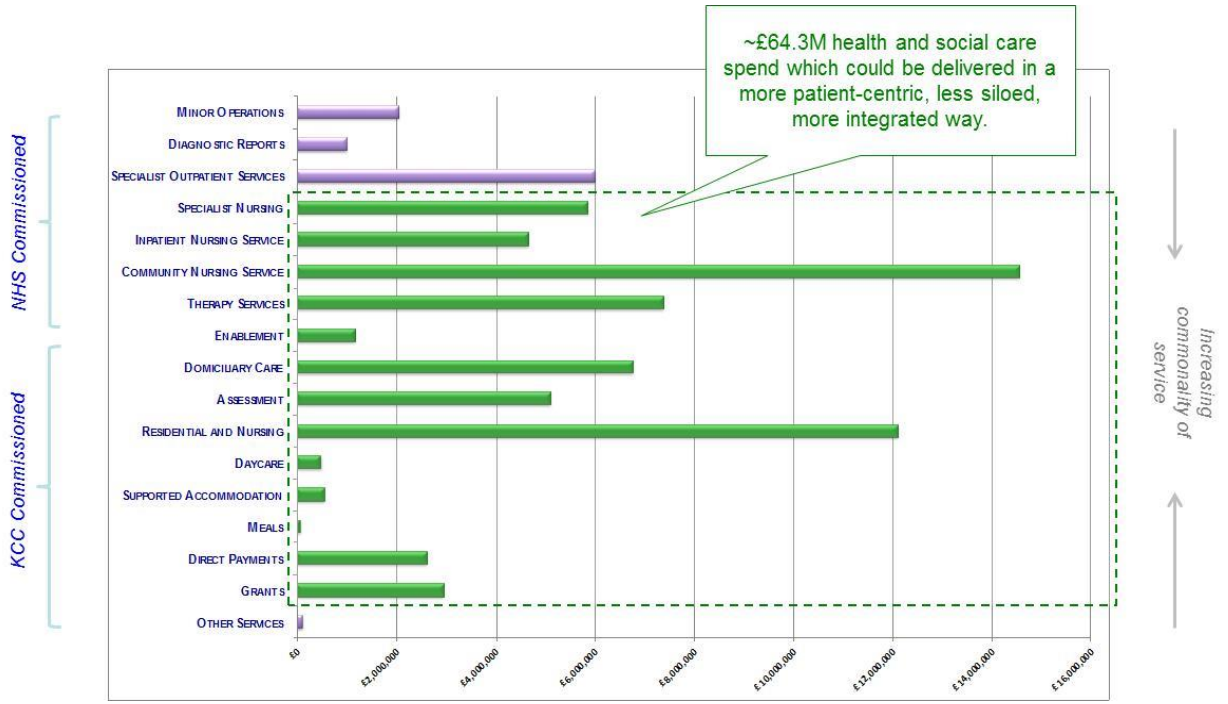
Tailored community based services e.g. :	Outpatients Specialist Diagnostics Addiction Services
Core community based health and social care services e.g. :	Assisted Living Befriending Care Homes Care Planning Carer Support Citizen's Advice Community Equipment Counselling Services Community Nursing Dementia 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

Enabler: The Better Care Fund

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.

Enabler: Medical Interoperability Gateway (MIG)

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.

Enabler: Organisational Development

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 we planned to do. The CCGs also recognise that 2015/16 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.

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 CCG have recruited support to deliver a detailed year long OD programme, commencing with diagnostic workshops for staff, Governing Body and clinical leads in March and April, resulting in four key work streams that will focus on:

- leadership and people development
- vision, values, behaviour and culture
- communication, staff & clinical engagement
- recruitment, retention, performance & reward

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 memberships vision is owned by the Governing Body and used to underpin and drive strategic change.

People and Behaviour

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

Each Community Network 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.

Programme: Urgent Care

From	To
"My problem isn't an emergency but I do need care urgently, where do I go?"	"It doesn't matter who I contact when I need care urgently, everyone seems to know what is happening with my care."
"Why can't I see my GP at the weekend?"	"It's such a relief knowing I can see my GP any day during the week"
"A&E is always so busy"	"They came into my home and treated me there, I didn't need to go to hospital like I thought"
"I didn't really want to go into hospital, but here I am."	"We have care plans for all our residents, so we know exactly what to do when one is ill"
"Whenever one of our residents is ill we need to call am ambulance because we don't know who else to contact"	"I just called NHS111 and they made sure I was seen by the right person."
"Calling NHS111 or the evening doctor is a waste of time"	

Integrated Urgent Care Centre
The IUCC is an initiative which will bring together providers across health and social care settings under one management structure. The team will be responsible for working both within the Acute aspects of Hospitals (A&E, Clinical Decision Unit and Surgical Assessment Unit) and also the speciality inpatient wards, covering a 7 day per week service provision

Seven Day Primary Care
Doctors will treat patients at their surgeries seven days a week under fresh plans to help improve access for patients with long term conditions and to improve access for all patients. It means ill patients can receive GP services on Saturday and Sunday instead of using the out-of-hours doctor.
cover.

Minor Injury Units
Increase capacity and coverage of our MIU to reduce need for patients to attend A&E

Paramedic Practitioner
Paramedics who can give people emergency care at home, giving advice to colleagues and taking referrals to visit patients who have called 999 but don't necessarily need to go into hospital. They can also refer on to other health professionals for follow-up treatment

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

NHS 111/Out of Hours GP Service
Overarching objectives of future modelling include greater responsiveness of services, reduced duplication and greater integration. It is proposed that by re-configuring existing services, the health economy will improve health outcomes for patients, increase the number of out of hours treatments undertaken in a patient's home or place of residence, reduce the need for acute admission to Hospital and length of stay in Hospital and the overall experience for patients.

Programme: Long Term Conditions

From

"I spend too much time travelling to hospital with additional costs of parking just for a quick review of my care"

"I don't want to die in hospital, I'd rather be at home"

"Why should I wait until my illness becomes unmanageable before I am offer assistance."

"Mum just isn't herself these days, she forgets things and we just don't know where to turn to."

Cardiology
Undertake GP refresher on identification of cardiac diseases. Improved care planning supported by the Heart Failure Nursing Team and increase and appropriate usage of the GPwSI Service, including advice and guidance. Review procedure criteria for undertaking angioplasty

Chronic Kidney Disease
Improving detection in primary care through use of IT monitoring to identify changes in eGFR, creatinine and prescriptions to avoid admission, Improved outpatient discharge criteria, reducing the number of follow-up appointments and audit urgent admissions to understand the reason for attendance and/or admission

Diabetes
Type 2 Diabetes primary care training programme, Integrated Diabetes care pathway implementation

End of Life Care
Ensure more formal and named professional co-ordination between the main end of life providers (District Nurses, Pilgrims Hospice, EKHUFT and the ambulance service) to deliver a 15% reduction in both admission to hospitals and/or care home admissions for patients who are at the end of their life.

Neurology
Develop and enhance pathways of care with particular attention on reducing admissions for epilepsy, levels of prescribing and improving outcomes

Stroke
Enhance/redesign/manage prevention and primary care system to optimise detection and care planning

Dementia
To sustain diagnosis rates, increasing where practical, ensuring that at least 67.5% of patients in our anticipated prevalence has a diagnosis and to further develop, with our partners in Kent County Council and district councils, dementia friendly services

Age UK
Age UK's Integrated Care Programme operates across England. Through the programme Age UK staff and volunteers become members of primary care led multi-disciplinary teams, providing care in the local community.

Community Nursing
We intend to review all patients and set clear criteria for what constitutes "housebound", allowing patients to be discharged from the care our the nursing teams thus freeing up capacity for patients at greater need

To

"I only had to visit the hospital once, the rest of my care was offered locally."

"We were able to care for Mum at home until she died."

"My condition was picked up quickly and I was supported early. Consequently I was able to control my condition."

"Since Mum was diagnosed with dementia, we have received support from social services and Age UK"

Programme: Mental Health/Planned Care

From

"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."

"I just don't know whether the operation is right for me"

"Dad keeps falling over and we are spending most of our time up the hospital"

"All we needed to Mum to go home was the right equipment. This took days to arrive and so she was stuck in hospital"

Psychosis
The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs

Improving Access to Psychological Treatment
We are currently going through the procurement of improved IAPT services, ensure that we are able to meet the new Mental Health waiting times standards.

Orthopaedic Triage Service
Reduce primary care Orthopaedic referrals to through GP-triage and compliance with existing agreed clinical pathways

Personal Decision Aids
Personal Decision Aids (PDA) are designed to help people make decisions about difficult healthcare choices. Each PDA contains good quality information about all the options and the health problem, and questions to help patients make informed decisions about their treatment which focusses on their individual lifestyle and health needs

Dermatology
Review of community pathway with a view to re-procuring service, reducing fragmentation in current pathway

Wet Age-Related Macular Degeneration
Procurement of community based service to improve access for patients at reduced cost to the NHS

Falls Prevention and Treatment
Address the historically fragmented way health and social care services work together, starting from when an ambulance is called out to elderly faller, all the way to a person being assessed and referred for community based exercise programmes to prevent falls.

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

Community DVT Service
Implement town based model integrated with existing MIU or Primary Care facilities

Anti-Coagulation
Re-procured model ensuring both initiation and on-going monitoring within the community

To

"I feel confident that I am in control of my own care, supported by my GP"

"I am supported to live my life how I wish because I know that support is there when I need it."

"I was able to look at all my options and chose the one which best suited me.

"They gave Dad some exercises. He seems so much steadier on his feet these days."

"The equipment turned up the next day and Mum was back home where she wanted to be."

The Financial Challenge

The CCGs received a reduced allocation from the autumn statement, 1.4%, with growth per capita below 1% and some of the lowest in the country. In 2015/16 the main challenge and risk concerns delivery of planned benefits from Quality, Innovation, Productivity and Prevention (QIPP) schemes to fund the pressures above the funding growth.

NHS Ashford CCG

The plan balances in year, maintaining the 2014/15 surplus. However, it does not return the CCG to a 1% surplus within 15/16. A recovery plan has been submitted to NHS England in line with planning guidance. The plan details the actions being taken to address the longer term financial position of the CCG utilising the NHS Right Care approach to deliver value in commissioning.

NHS Canterbury and Coastal CCG

The plan delivers a 1% surplus, but assumes return of surplus from 2014/15 to fund some non recurrent investments in Mental Health, Community Networks (MCP development) and the NHS Right Care program.

Activity

The contract with the main acute providers are being planned at the previous years contract out turn levels with the exception of areas where additional activity is needed to achieve constitutional targets. The CCGs have implemented referral management services and non elective changes that will maintain the activity at these levels. Further QIPP/Commissioning for Value savings are required to reduce the contracts below 14/15 out turn to fund pressures in CHC, prescribing and national initiatives such as parity of esteem. The main activity reductions are within urgent care, with an expected reduction of between 2-3 admissions per site per day.

There is a there is tension with the Better Care Fund (BCF) in this area where CCG schemes outside of those in the BCF are required to balance the plan rather than fund the pay for performance element of the BCF. Clear monitoring and delivery reporting is required to demonstrate the causality of activity reductions and the individual schemes. The BCF is being finalised with KCC and whilst the level of integration could be greater, KCC are integral partners in the community networks and the governance structures within the section 75 have been operating for the last year.

Parity of Esteem

The KMPT contract is being increased through further investment in additional bed capacity and the rebasing of the contract from fair shares. In addition the joint management of CHC patients is expected to increase the contract whilst generating overall savings to the health economy.

QIPP/Commissioning for Value

Through revision of the planning and contract discussions with providers the QIPP target has been reduced to 2% for Canterbury and 3.1% for Ashford. The main schemes are :

- Continuation, and expansion to other specialities, of the orthopaedic triage and management process
- Reduction in HCD expenditure through use of best practice and potential drug alternative s such as bio similar products
- Roll out of the successful winter schemes and implementation of IUCC to reduce unscheduled care admissions
- Review of community nursing staff provision and OOH services
- Securing better value in CHC placements through market and process management
- Review of products supplied to care homes
- Continued implementation of the NHS Right Care programme

The approach to CCG QIPP in 2015/16 is an extension to the approach in 14/15, with most savings being identified jointly, jointly managed and delivered with all parties sharing the cost savings. There are other saving plans there are a higher risk on as we look to pull non elective activity from East Kent Hospitals University NHS Foundation Trust and will require them to close beds to make cost savings. The risk is the contracts work on cost, and in the example of shutting beds, as the trust currently operate at c.95-98% occupancy there is a quality and safety requirement to reduce this before savings can be released.

Schemes within the EKHUFT contract

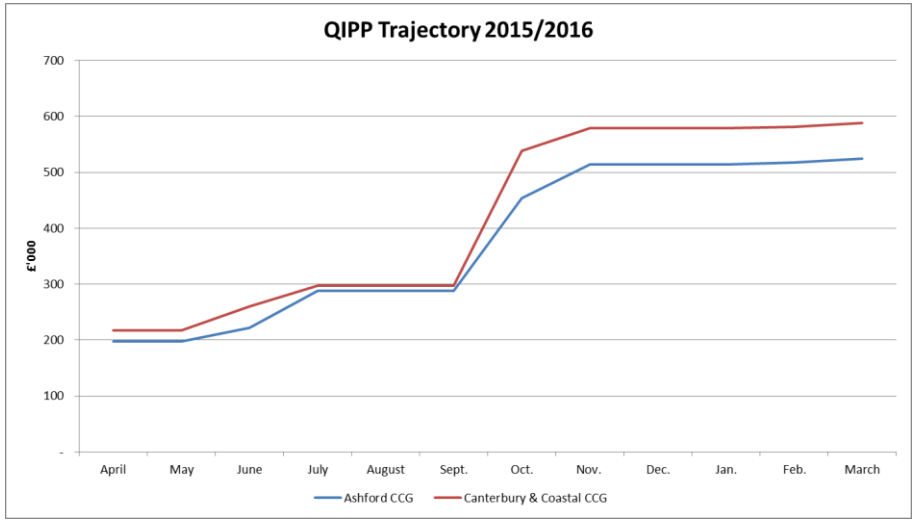
We will continue and expand the referral management approaches in the CCG, the first 3 months of which have shown 35-45% reduction in orthopaedic referrals. We are looking to expand the models to include other pressured services including Dermatology, ENT and General Surgery.

The main area of focus in reducing our usage of high cost drugs are specifically related to our Wet AMD project and the implementation of the "Southampton Model" for rheumatology which together could save in the region of £6m for a full year.

Despite poor A&E achievement, locally the growth in A&E attendances and subsequent admissions was relatively low, 3% or so in Ashford and Canterbury. The CCG is looking to continue our investment in Integrated Urgent care centre, LRU and integrated discharge team to reduce. The savings included in QIPP equate to 2 or 3 admissions per site per day, which has been achieved during the early implementation phase funded through winter resilience.

With partners, we will set up joint funded assessment service for patients fit for discharge that otherwise would be DTOCs or admitted to care homes. This model will discharge to the appropriate setting and thus save the whole health and social care economy.

NHS Right Care – the CCGs have a number of pathway reviews in place under the remit of right care, CKD alone could save £1.6m between the CCGs. These will take longer to implement but work has started on these with the second session in April.



Schemes within Mental Health

The CCG's in east Kent are discussing with KMPT the potential to better manage patients placed outside of the provider due to capacity constraints and inefficiencies and the management of CHC patients in a better, more planned way. Should the Trust withdraw from this plan the CCG will revise the process for approval of CHC placements, increasing the clinical challenge to the panel and ensuring the rules and processes are rigidly applied.

Schemes within Prescribing

Both CCGs have agreed a 2 year incentive scheme based on the Isle of Wight model that delivered a significant reduction on prescription costs. The risk is the CCGs are currently the two of the most efficient prescribers in Kent, but the final astro-PU value in the IoW is lower than both CCGs current performance.

Schemes within Funded Nursing Care

Ashford CCG has proportionately the highest FNC usage in east Kent, and there are a number of areas where we are picking up costs for other CCG's and Governmental bodies including KCC. The CCG is reviewing these and the planned savings are the target set on early understanding / benchmarking where available.

Commissioning for Quality and Innovation (CQUIN)

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, we have decided to have seven local measures; four shared across both our community and acute providers and to further support our strategic ambition to close the gap between mental and physical health, we have devised 3 local quality incentives with our main mental health provider.

National CQUIN

Acute Kidney Injury	Sepsis	Dementia and Delirium
2015/16	2015/16	2015/16
To improve the follow up and recovery for individuals who have sustained AKI, reducing the risks of readmission, re-establishing medication for other long term conditions and improving follow up of episodes of AKI which is associated with increased cardiovascular risk in the long term.	Providers are expected to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.	To support the identification of patients with dementia and delirium, alone and in combination alongside other medical conditions. It aims to prompt appropriate referral, follow up, and effective communication between providers and general practice, through the introduction of a care plan on discharge; after the patient is discharged from hospital or community services following an episode of emergency unplanned care.

Mental Health CQUIN

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

Acute and Community CQUIN

COPD	Over 75s (with Long Term Condition)	Diabetes	Heart Failure
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

Commissioning Projects 2015-16

	Anticpated Outcome	Standard	A	M	J	J	A	S	O	N	D	J	F	M	2016-17
Urgent Care															
– Integrated Urgent Care Centre	Reduction in A&E Attendances	A&E Constitution													
– Seven Day Primary Care	Reduction in A&E Attendances	Five Year Forward View													
– Minor Injuries Units	Reduction in A&E Attendances	A&E Constitution													
– Care Homes Support	Reduction in Non-Elective Admissions	Better Care Fund													
– Paramedic Practitioner	Reduction in Non-Elective Admissions	A&E Constitution													
– NHS 111 Procurement	Reduction in A&E Attendances	A&E Constitution													
Planned Care															
– Orthopaedics Triage Service	Reduction in referrals and procedures	RTT Constitution													
– Rheumatology	Reduction in referrals	RTT Constitution													
– Personal Decision Aids	Reduction in referrals and procedures	RTT Constitution													
– Dermatology	Reduction in referrals	RTT Constitution													
– Wet Age-Related Macular Degeneration	Reduced cost of treatment	RTT Constitution													
– Falls Prevention and Treatment	Reduction in Non-Elective Admissions	Better Care Fund													
– Community Loan Store	Earlier discharge from inpatient episode	A&E Constitution													
– Community DVT Service	Reduction in referrals	RTT Constitution													
– Anti-Coagulation Service	Reduction in referrals	RTT Constitution													
– Breast Cancer	Reduction in referrals	Cancer Constitution													
Mental Health															
– Care Programme Approach	Reduce admissions, increased employment	NHS Right Care													
– IAPT Procurement	Improved choice, access and recovery	Mental Health Constitution													
Long Term Conditions															
– Cardiology	Earlier identification, Reduced non-elective admissions	NHS Right Care													
– Chronic Kidney Disease	Earlier identification, Reduced non-elective admissions	NHS Right Care													
– Diabetes	Community based care	RTT Constitution													
– End of Life Care	Community based care	A&E Constitution													
– Neurology		NHS Right Care													
– Stroke		NHS Right Care													
– Dementia	Earlier diagnosis	Five Year Forward View													
– Age UK	Reduction in referrals	A&E Constitution													
– Reducing Community Nursing Demand	Increase capacity	A&E Constitution													
Child Health and Maternity															
– Children's Strategy															

Health Reform Group - New Cases

Health Reform Group - Post Implementation Review