Agenda Item No: 6

Report To: **Ashford Health & Wellbeing Board**

Date:

Report Title: CCG Annual Operating Plan

Report Author: Neil Fisher, Head of Strategy and Planning
NHS Ashford CCG

Organisation:

Summary:	At this point annually, the CCG is asked to produce an Annual Operating Plan (AOP) detailing out commissioning intentions for the forthcoming financial year. This document is a work in progress, with the final submission to NHS England due on 4th April 2016. The current draft still requires amendment in line with some of the feedback received from NHS England – most notably relating to the CCG actions to address constitutional standards. Additionally, Better Care Fund guidance was published on 22nd February and has not therefore been taken into account in developing this version of the Plan.

Recommendations:	**The Ashford Health & Wellbeing Board be asked to:-** Formally support current draft and offer direction for updated versions. The final AOP will be shared across our membership, community networks and public meetings and shared with the membership of the HWBB.

Background Papers:

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Annual Operating Plan 2016/17

NHS Ashford Clinical Commissioning Group
NHS Canterbury & Coastal Clinical Commissioning Group

DRAFT
Version 1.5

Context

Political, Economic and Service Pressures

As we enter the third year of CCGs, the NHS faces a number of local and national challenges. Each of these has an impact on how we will commission services, for the residents of both Ashford and Canterbury areas, in the coming years.

- **East Kent Hospitals NHS University Foundation Trust has recently been re-visited by the Care Quality Commission (CQC) and. Whilst the position has improved since the initial visit, their report continues to raise a number of concerns about the quality of local services.**
- **Workforce continues to be a challenge for all NHS organisations across the country, both in terms of increasing demand by also in the reduced numbers of doctors and nurses being trained. Additionally, sub-specialisation puts additional pressure on the training of the consultants of the future.**
- **NHS Constitutional targets, relating to waiting times for surgery, A&E and cancer, continue to drive much of how we commission services, increasing demands offer additional pressure on our ability to achieve these standards.**
- **The 2020 Financial Challenge for the NHS to save £30bn is also felt locally, leading to continuous budget restraints and greater focus on ensuring that we commission the best outcomes but a lower overall cost to the NHS budgets.**
- **The facilities from which local services are delivered are a mix of both old and new. Additionally they are based on historical patterns of need and no longer meet the demands of a modern national health service. We continue to work within these constraints, however this is not sustainable in the longer term.**
- **The expectations of our patients continues to rise. From waiting times, to the localisation of services and the difficulty in access for those patients reliant on public transport. From a greater focus on services in the community, to reduction in the need to travel further afield for specialist services. Each of these, and other expectations, of our local population also drive much of how we commission services.**

All of this leads to an unsustainable pattern of services and service provision. As such across east Kent we are currently working on a five-year Sustainability and Transformation Plan which will show our population how your local NHS intends to address each of these concerns. This document represents the first year of that plan and is based on the foundation we have laid in the first two years of our existence.

Context

NHS Ashford CCG Health Profile

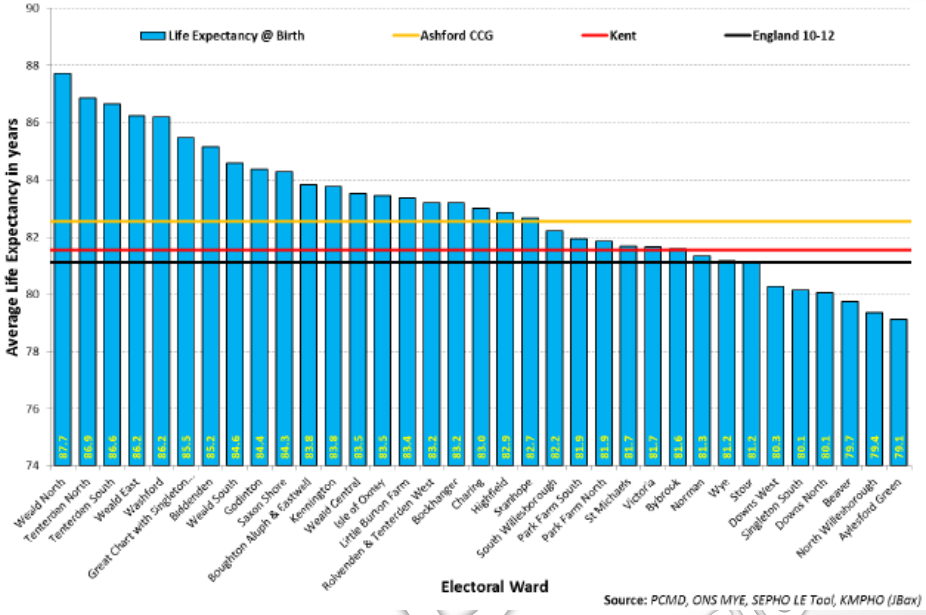
The registered population for NHS Ashford CCG was 126,400 as of 31/12/2014 Overall Ashford broadly presents a similar proportional representation for each age band compared to Kent, however there are a few slight differences between the two with Ashford presenting a higher proportion of 0-14 and 40-49 year old females and 5-19 and 40-54 year old males. Whereas in both genders there is a slightly smaller representation of 20-24s, 55-64s and those aged 70+. The predicted trends for males aged 65+ and 85+ are what you'd expect as they're showing a gradual increase in numbers over the next 24 years which will require innovative service planning for the future in order to cope with the needs and demands of the older population.

The Ashford CCG area has a life expectancy of 82.5 years making it the highest of all the Kent CCGS and significantly higher than the Kent & England averages. The highest life expectancy from birth is in Weald North ward at 87.7 years, there are 25 wards in Ashford CCG with a significantly higher life expectancy compared to Kent and 6 wards are significantly worse than the England average. The ward with the lowest life expectancy is Aylesford Green at 79.1 years; 2.4 years lower than the Kent average.

As the CCG Outcomes Tool, shown on the following page, demonstrates the CCG has made progress against a number of indicators, although needs to reflect on the deterioration against others. In many cases, the CCG compares favourably against the England average, even in those where our performance has not improved.

Significantly, "the years of life lost" indicator has deteriorated for both females and males. We are also pleased to note the significant improvement in access to psychological therapies, which is a reflection of our investment in Mental Health services.

The main concern in these indicators relate to cancer outcomes, this is reflected in the prioritisation we have given to two cancer projects in this years plan.



What have we achieved to date?

NHS Outcomes Tool Highlights – NHS Ashford CCG

Indicator Name	Value		Spine chart		
1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare - Female (2014)	1,726	↑	1055		3204
1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare - Male (2014)	1,787	↑	1325		3902
1.2 Under 75 mortality rates from cardiovascular disease (2014)	57.2	↑	35.7		127.2
1.17 Record of stage of cancer at diagnosis (2013)	49.1	↓	38.9		86
1.18 Percentage of cancers detected at stage 1 and 2 (2013)	29.3	↓	21.3		60.6
1.22 Hip fracture: incidence (Jul 2014 - Jun 2015)	524	↓	55		584
2.1 Health-related quality of life for people with long-term conditions (2014/15)	0.77	↑	0.63		0.81
2.2 Proportion of people who are feeling supported to manage their condition (2014/15)	67.2	↑	50.6		75.3
2.10 Access to psychological therapies services by people from Black and Minority Ethnic (BME) groups (2014/15)	847	↓	242		2882
2.11a Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable recovery following completion of treatment (2014/15)	51.0	↑	17.6		64.6
2.11b Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable improvement following completion of treatment (2014/15)	68.9	↑	24.8		76.8
3.1 Emergency admissions for acute conditions that should not usually require hospital admission (Jul 2014 - Jun 2015)	1,251	↑	252		2368
3.2 Emergency readmissions within 30 days of discharge from hospital (2011/12)	12.1	↑	8.9		14.5
3.6 People who have had an acute stroke who receive thrombolysis (2014/15)	20.30	↓	0.8		27.4
3.7 People with stroke who are discharged from hospital with a joint health and social care plan (2014/15)	94.1	↑	1.3		100
3.8 People who have a follow-up assessment between 4 and 8 months after initial admission for stroke (2014/15)	18.90	↑	0		89.6
4.1 Patient experience of GP out-of-hours services (2014/15)	65.2	↑	49		85.3
5.3 Incidence of Healthcare Associated Infection (HCAI) – Methicillin-resistant Staphylococcus aureus (MRSA) (Apr 2013 - Sep 2015)	2.35		0		9.98
5.4 Incidence of Healthcare Associated Infection (HCAI) – C. difficile (Apr 2013 - Sep 2015)	55.6		24		133

In worst quartile ● In IQ range ● In best quartile ● Sig change ↓ ↓ ↓ ↑ ↑ ↑ Non-sig change ↓ ↓ ↓ ↑ ↑ ↑ No change –
England Mean | Cluster mean ◆

Context

NHS Canterbury and Coastal CCG Health Profile

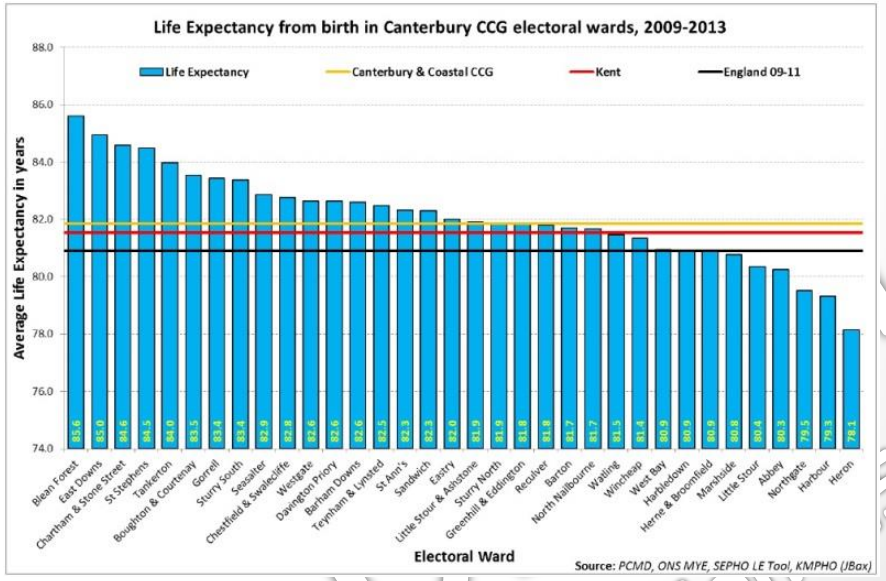
The registered population for Canterbury & Coastal CCG at 31/12/2014 was 215,285 with significant transient student population leading to a much larger percentage of 15-24 year olds compared to the England average. The predicted trends for population aged 65+ and 85+ are showing a gradual increase in numbers over the next 24 years and approximately one quarter of the Canterbury & Coastal CCG population will be aged over 65 by 2037. This will require innovative service planning for the future in order to cope with the needs and demands of the ageing population. We estimate that, based on the current district council local plans there would be an increased population of 33,540 people by 2031.

The Canterbury & Coastal CCG area has a life expectancy of 81.9 years making it higher than the Kent & England averages. The highest life expectancy from birth is in Blean Forest ward at 85.6 years, there are 23 wards in Canterbury & Coastal CCG with a significantly higher life expectancy compared to Kent and 6 wards are significantly worse than the England average.

As the CCG Outcomes Tool, shown on the following page, demonstrates the CCG has made progress against a number of indicators, although needs to reflect on the deterioration against others. In many cases, the CCG compares favourably against the England average, even in those where our performance has not improved.

Significantly, “the years of life lost” indicator for males has improved, whilst there is a deterioration for females. We are also pleased to note the significant improvement in access to psychological therapies, which is a reflection of our investment in Mental Health services.

The main concern in these indicators relate to cancer outcomes, this is reflected in the prioritisation we have given to two cancer projects in this years plan.



What have we achieved to date?

NHS Outcomes Tool Highlights – NHS Canterbury and Coastal CCG

The National 'Must Dos'

Whilst developing our local Annual Operating Plan, we are required by NHS England to ensure that we plan to meet priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation. Included in this are the following objectives:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.
2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.
4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.
6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

Sustainability and Transformation

What will your NHS look like in 2020?

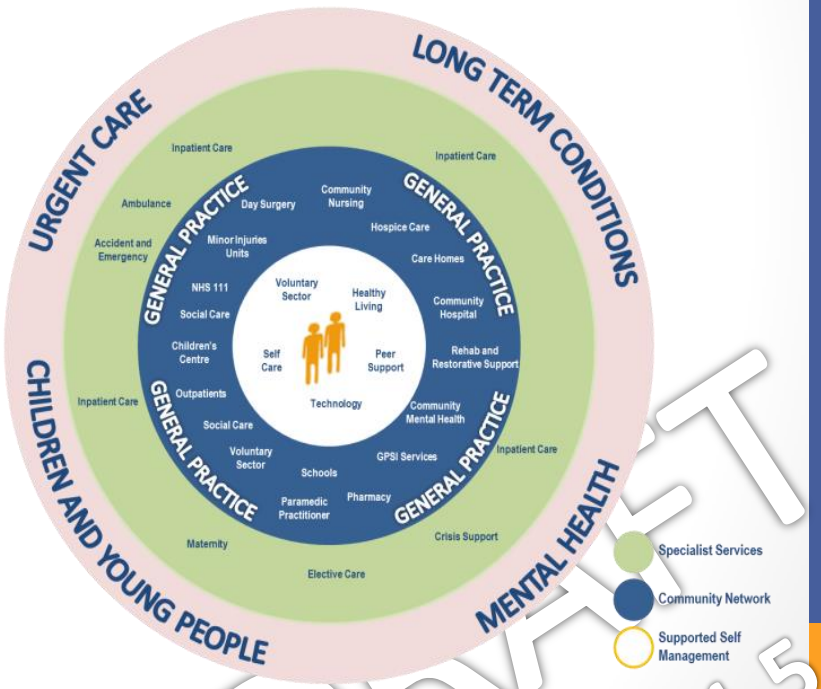
In October 2014, NHS England published "Five Year Forward View" (5YFV), which set out their vision for services over the coming five years. This document identifies that, in order to meet patients' needs and expectations, we need to dissolve traditional boundaries. Long term conditions are now the central focus of the NHS commissioners; caring for these needs requires 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 which the NHS needs to take. Increasingly we need to manage systems – networks of care – not just organisations. We need to ensure that we have comprehensive, integrated local care and health services which are;

- tailored to communities
- provided through Multispecialty Community Providers (MCP)
- supported by a chain of high quality, smaller, acute hospitals with access to safer specialist service

Both NHS Ashford CCG and Canterbury and Coastal CCG are in a good position to deliver against these expectations. Our initial five year strategic vision, which was published in 2014, clearly set out our intention to transform our services towards a more community centric approach through our Community Networks approach.

Additionally, we are fortunate to have a national exemplar model – Encompass – which is currently being delivered across the Whitstable, Canterbury and Faversham areas and is designed to test out these new models of care.

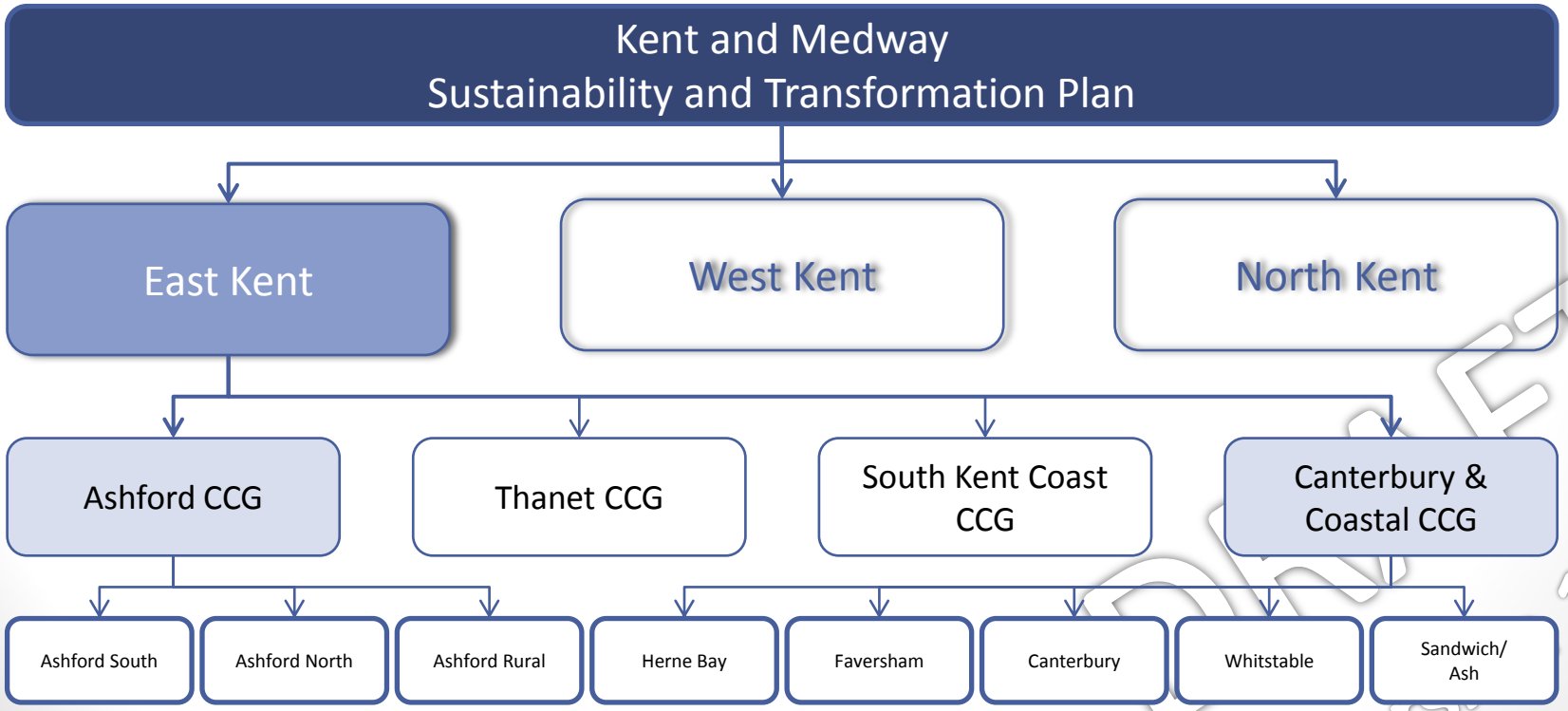


What will your NHS look like in 2020?

Sustainability and Transformation Plan (STP)

Some of the services commissioned by the CCG, particularly those around urgent and emergency care such as trauma, stroke and vascular are commissioned countywide. As a consequence of this there will be a single STP, with a Kent and Medway Board providing assurance on the plan to NHS England. As part of the STP, in order to reflect the differing needs across the county, there will also be sections of the plan covering each of the three health economies, north, west and east.

We will also retain the Community Networks approach designed 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

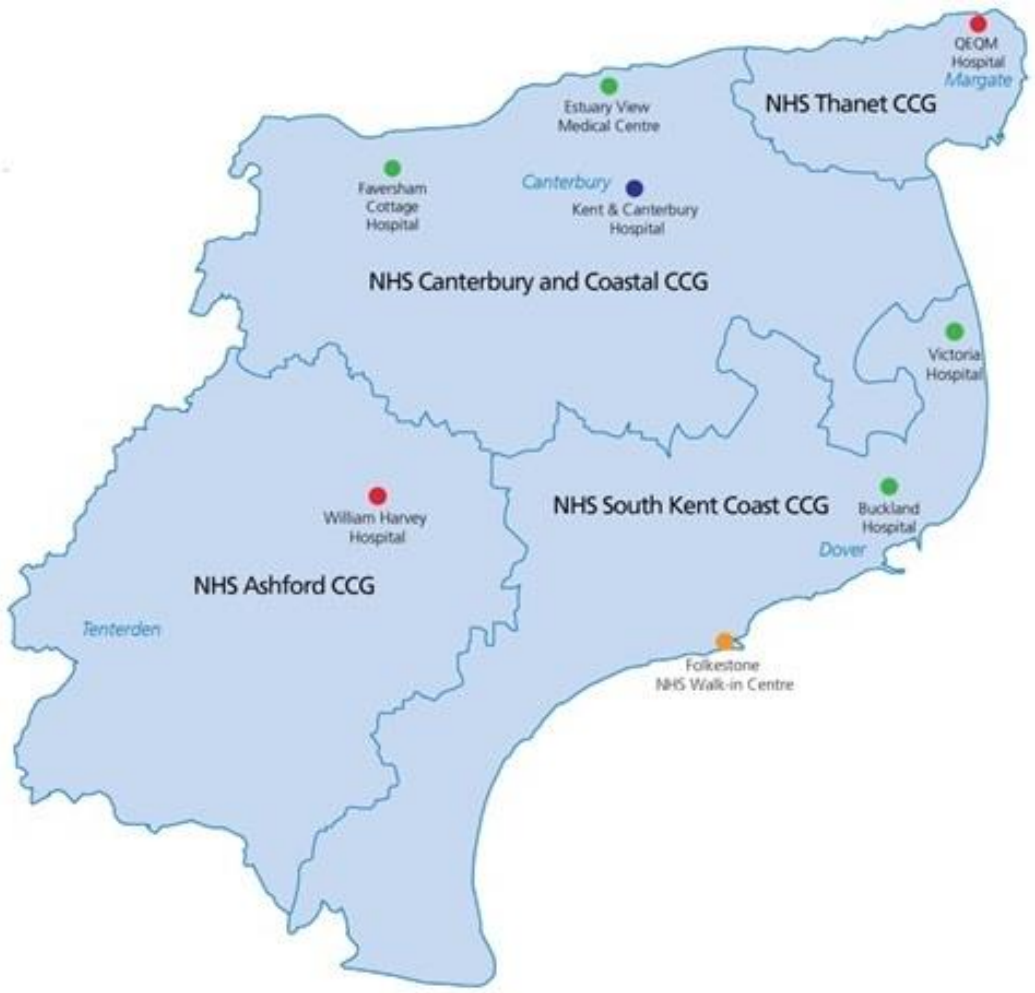


What will your NHS look like in 2020?

Achieving Sustainability Across East Kent

Neither Ashford CCG nor Canterbury CCG operates completely in isolation but is part of a wider health and social care community. As such, when it comes to planning for the future needs of our patients and the wider community, we work closely with our partners from across East Kent.

With all organisations involved in the planning, provision and delivery of health and care services in this area, we have recently established the East Kent Strategy Board to spearhead a new drive to determine how best to provide health and care services to the population of east Kent in the future. Membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services and will oversee a programme of design work over the coming months that will set out proposals for a new pattern of services across east Kent. The work is clinically led, working closely with staff, patients, carers and the local community to co-design solutions to meet the challenges we face.



NHS Ashford Clinical Commissioning Group
NHS Canterbury & Coastal Clinical Commissioning Group

How will we get there?

An East Kent Strategy and Roadmap

In order to achieve the level of sustainability our services require in order to meet the future need of our patients, there are clear steps which any transformational change will need to undertake. The Kings Fund give a sense of the direction which we will need to be taking:

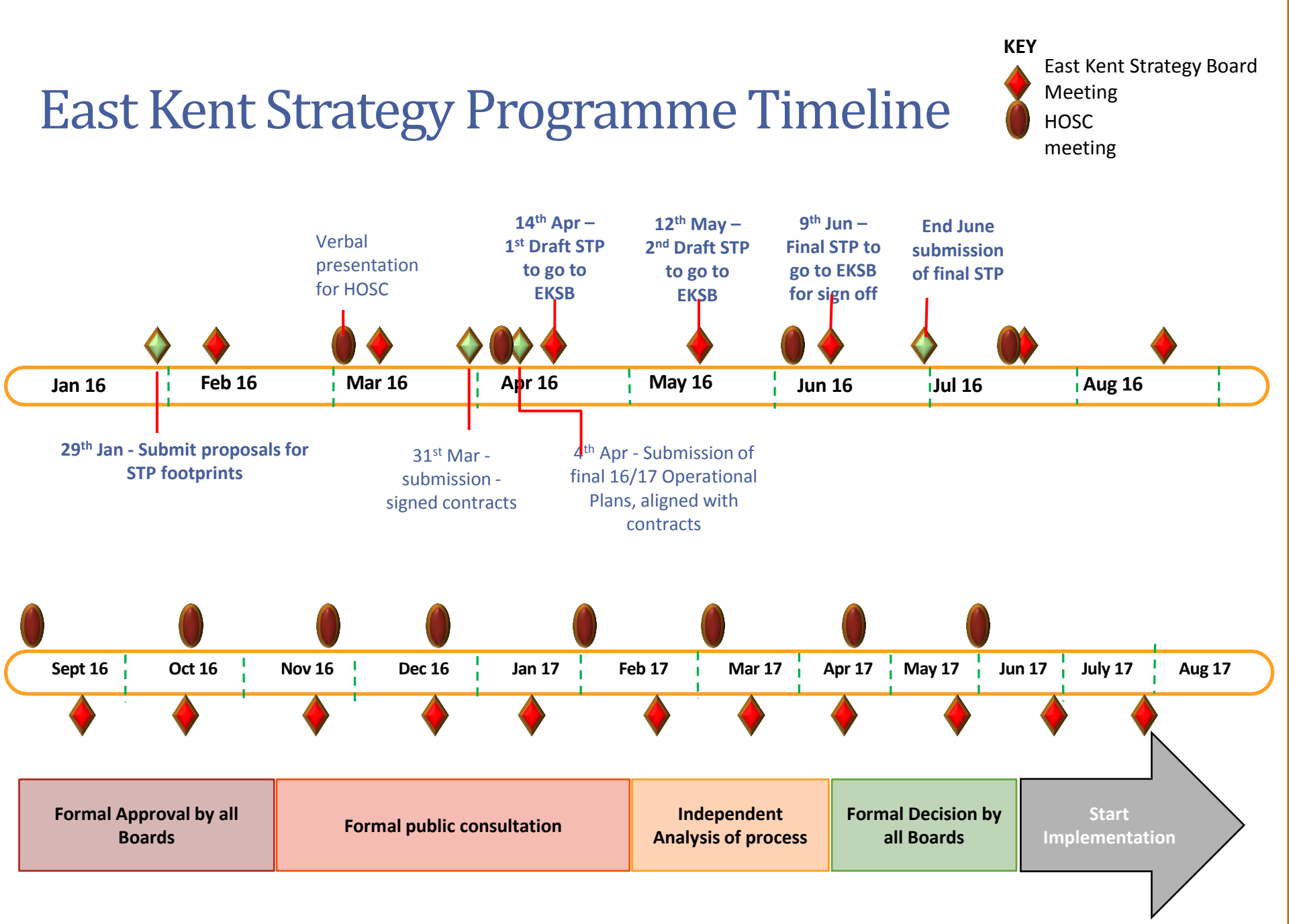
- Simplify services and remove unnecessary complexity.
- Wrap multidisciplinary teams around groups of practices, including mental health, social care, specialist nursing and community resources.
- Use these services to build multidisciplinary care teams for patients with complex needs.
- Support these teams with new models of specialist input.
- Develop teams and services to provide support to patients as an alternative to admission or hospital stay.
- Build the information infrastructure, workforce, and ways of working and commissioning that are required to support this.
- Reach out into the wider community to improve prevention, provide support for isolated people, and create healthy communities

Whilst the East Kent Strategy Board has not yet considered or tested any options for change, and no decisions about how services might be organised in the future have been made, the Five Year Forward View sets out a clear direction of travel for the NHS as a whole. Currently, based on our previous five year strategic plan, the roadmap for change would run as follows:

In Place	2016/17	2017/18	2018/19	2019/20
• **Community Networks** • **Canterbury, Whitstable and Faversham MCP (Encompass)** *- Commenced*	• **East Kent Clinical Strategy** - *Development* • **Encompass** - *Phase 2* • **Ashford Integrated Care** - *Phase 1* • **Herne Bay Integrated Care** *- Phase 1*	• **East Kent Clinical Strategy** - *Phase 1* • **Encompass** - *Phase 3* • **Ashford Integrated Care** - *Phase 2* • **Herne Bay Integrated Care** - *Phase 2*	• **East Kent Clinical Strategy** - *Phase 2* • **Encompass** - *Phase 4* • **Ashford Integrated Care** - *Phase 3* • **Herne Bay Integrated Care** - *Phase 3*	• Smaller, safer, more specialist secondary care services • Secondary care (physical and mental health) support to primary care out of hospital • Out of hospital provision through Multispecialty Community Providers (MCP) • Access conducive to decrease health inequalities

NHS Ashford Clinical Commissioning Group
NHS Canterbury & Coastal Clinical Commissioning Group

East Kent Strategy Programme Timeline



New Models of Care

NHS Vanguard - Encompass

Encompass – previously known as the Whitstable, Faversham and Canterbury Community NHS Vanguard - seeks to deliver an integrated health and social care model of care through the transformation of local services to deliver proactive care and support focused on promoting health and wellness, rather than care and support that is solely reactive to ill health.

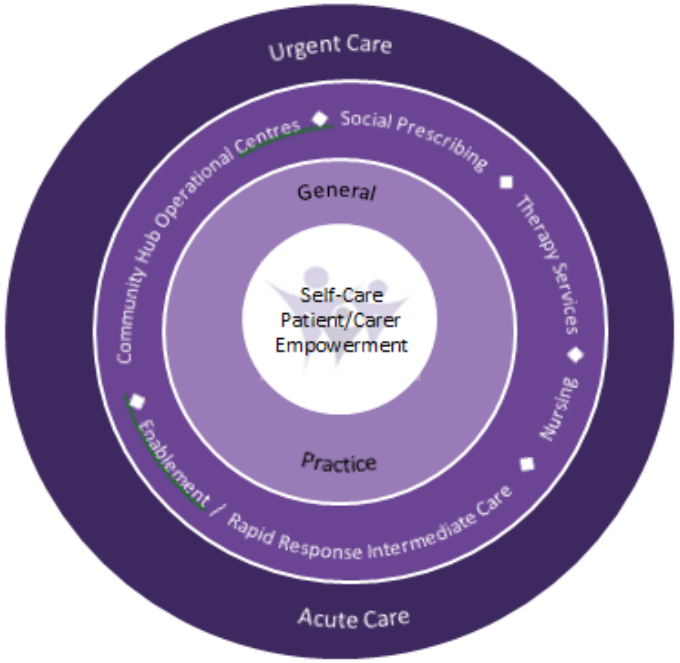
The MCP integrated model of care will deliver holistic health and social care services through **Community Hub Operating Centres (CHOCs)** located in Whitstable, Canterbury, Faversham and Sandwich. Each CHOC will support clusters of GP practices. Although there will be room for local variation in each CHOC, to enable services to be tailored to meet specific population needs. We are working to confirm the CHOC sites, with a view to collocating them with existing community health facilities. For example, the Whitstable CHOC is likely to operate from Estuary View Medical Centre, which already houses a range of outpatient and diagnostic services and an MIU. Sites for the other CHOCs are being finalised.

Each hub will incorporate:

- General Practice
- Integrated nursing and social care (including domiciliary care)
- Functional therapy services
- Access to voluntary and community service via social prescribing
- Health promotion and prevention services
- Integrated mental health services

encompass
Working together for better health and care

Schematic of the Model of Care



Enablers for effective service integration

- IT Integration
- Patient Engagement
- Patient Empowerment / Self Care
- Transport to facilitate people being supported in the community setting

NHS Ashford Clinical Commissioning Group
NHS Canterbury & Coastal Clinical Commissioning Group

New Models of Care

Fast Follower – Ashford Community Providers

We also have the development in Ashford as a 'fast follower' with clinical lead from Ashford Clinical Providers (ACP) now a member of Vanguard (E**n**compass) MCP Steering Group.

Ashford Clinical Providers recognise that commissioning needs robust locality wide cost effective alternatives to allow shift from hospital to community built on the strengths of local Primary care. Shared early outcomes from key Vanguard projects have enabled ACP to refresh their plans and adopt a similar integrated hub model approach across three localities based on the following geography:

- Ashford South
- Ashford North
- Ashford Rural

Achievements To Date

ACP already have a track record of delivering changes to local services. In 2015, with help from additional funding from the CCG, ACP trialed weekend opening of GP services in both North and South Hubs, to complement the existing service in the Rural Hub.

In 2015, ACP started delivering an Orthopaedic referral triage pilot which has successfully redirected 33% of patients to community GPSi (Limb) and ESP (spinal) services. The service has provided savings for the local health economy, streamlined patient care closer to home, decreased pressure on local secondary care outpatient services AND built capacity in the existing Community MSK provider service which has lower tariffs.

Long Term Plans

In the longer term, ACP are aiming for more timely access to health and social care needs through service redesign including:

- Weekend/evening GP access in all 3 Ashford Hubs.
- IT integration (EMIS Web with MIG)
- Ever expanding GPSi and consultant delivered local patient triage, assessment and treatment services
- In partnership with the CCG further develop the rural hub model of weekend working
- Integration of the Community Teams into primary care with the help of the CCG
- Relocation of care/community teams (mental health, health visitor, midwife, social worker, district and community nurses etc).
- Acute care collaboration between ACP and EKHUFT.

New Models of Care

Herne Bay Integrated Care Centre (ICC)

The vision for the Herne Bay Integrated Care Centre is to commission "A resource for the community where primary and community care will work together to relieve pressure on the local health economy by providing a wide range of services closer to patient's homes", with the intention to base the centre at the Queen Victoria Memorial Hospital (QVMH)

The ICC will act as a hub where patients will be able to access a range of urgent and outreach services including access to diagnostics. This will include minor injury and illness, urology, DVT, wound and day case clinics. The service will be delivered in accordance with the 'Priority Three'. The service will be nurse led with GP oversight provided by all four local practices with support from the Community Network to ensure maximum interface between primary and community care.

Current services of this nature are not located locally to the population of Herne Bay, requiring travel to Canterbury, Margate or Whitstable with limited public transport options. Care will be overseen by local GPs to ensure the patients are known and to identify where core primary care services need strengthening to reduce the burden on other services. The ICC will provide advice including self-care and social care which can be wrapped around the patients' needs, will help to reduce the impact of any potential downgrading or changes to acute services and will assist in ensuring the viability and suitability of the community hospital in the context of a growing population need in the locality.

The ICC will be the first step towards the delivery of patient-centric, integrated health and social care services across Herne Bay driven by primary care and supported by the Community Network.

Phase 1

- Nurse/paramedic practitioner led ICC (including minor injuries) supported by GP surgeries
- Linked IT between the centre and the practices
- Nurse led urology clinic for planned and urgent care
- Utilising existing (albeit limited) x-ray facilities

Phase 2

- Day case procedures T&O hand and wrist
- Extended hours GP clinic
- DVT clinic
- Improved diagnostic services – co-located x-ray, ultrasound and MRI facility
- Improved mental health care planning
- Appropriate diversions for ambulance services to reduce pressure on urgent and emergency facilities
- Integrated working with existing wound care clinic, community nursing team and voluntary services

Phase 3

- Develop urgent appointment facilities for existing ophthalmology and ENT services
- Ambulatory care unit
- Focused service to assist care for young families in non-clinical settings
- Host specialist primary care based MDT clinics for the locality in areas of significant spend i.e. respiratory and diabetes

Better Care Fund

The development of new models of care 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.

Building on a long history of joint commissioning of services, the Better Care Fund provides further opportunity to commission services together. We will use this 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

INSERT OUTCOMES AN PLANS FOR 2016

General Practice

Sustainability and Quality

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. 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. General practice and wider primary care services in England have a number of internationally recognised strengths:

- Registered lists are a key tool in the coordination and continuity of care; the vast majority of the population is registered with a general practice in the UK
- There is a strong generalist tradition in the NHS; general practice is well placed to utilise its knowledge of patients and their families in a local community gained from repeated consultations over time to holistically improve physical, emotional and social wellbeing
- General practice, plays a central role in the management of people with chronic disease and identifies those at risk of worsening chronic ill health
- General practice displays a highly systematic use of information technology to support the management of long term conditions, track changes in health status and support population health interventions such as screening and immunisation
- There are numerous examples of innovation in general practice leading to improvements in quality of care and wider service transformation

If we stand still on the improvement ladder, we will fail to progress and meet the evolving needs and expectations of our population. For this reason, improving the quality of primary care services for the our diverse population is a priority for the CCG serving this population, working in partnership with and in collaboration with patients, our GP membership, local authorities (LAs), and other key stakeholders.

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

General Practice
Strategy Group

Strategic Objective
Aim to balance the benefit of small and local organisations with the scale and capacity to improve quality and deliver a wider range of services

The Primary Care Strategy Group was created to oversee the development and implementation of a strategy for primary care within NHS Ashford and NHS Canterbury and Coastal CCGs that reflects the needs of the local population and which will meet the objectives within the CCGs Strategic Commissioning Plans and to inform CCG approach to co-commissioning in line with "Five Year Forward View"

Additionally the group was tasked with:

- Leading the development, implementation and monitoring of a new model for primary care in NHS Ashford and NHS Canterbury and Coastal CCGs, working collaboratively with other agencies
- Advising on workforce plans that support the achievement of the primary care strategy and aim to maximise the recruitment and retention of professionals and support staff;
- The group comprised
    - 1 representative from each of the 8 community networks
    - CCG Chairs
    - CCG Chief Operating Officer
    - CCG Head of Strategy and Planning
    - CCG Primary Care Workforce Tutor
    - Kent LMC representative
    - NHS England (Kent and Medway Area Team) representative

General Practice

Our Ambitions

Following discussion with the GP membership of the CCG, the Primary Care Strategy Group have identified eight ambitions which they believe with improve local services for our patients, specifically these are;

Ambition 1 – Patient Access.

Every patient will have access to a core offer of high quality primary care which is continuously improving and delivering excellent health outcomes.

Ambition 2 – Patient Participation.

We will have effective engagement with our patients, and their carers, to ensure that our services and information meet their needs and lifestyles.

Ambition 3 – Workforce.

We will have an attractive training environment which develops our doctors, nurses and allied staff to be the best healthcare workforce.

Ambition 4 – Premises.

The premises used to deliver services will be fit for purpose meeting the current, and future, needs of our growing population

Ambition 5 – Quality and Outcomes.

Every patient will have access to a core offer of high quality primary care which is continuously improving and delivering excellent health outcomes.

Ambition 6 – Integration.

Patient care by removing boundaries between primary, community, hospital and social care.

Ambition 7 – Technology.

We will use technology to deliver the highest quality care in the most appropriate manner.

Ambition 8 – Payment and Investment.

We will ensure that there is a payment and incentive system to support improved outcomes, ensure value for money and reflect the workload.

Achieving Constitution Standards

Urgent Care Standards

Performance against this target continues to be poor despite repeated attempts by the commissioning team to drive improvement have proved ineffective. A number of interlinked programmes have been introduced in order to help reduce pressure on our Accident and Emergency Departments, and further steps are being introduced to further improve services.

In Hospital

- New site management arrangements on all 3 main hospital sites
- Health and Social care partners agreeing support arrangements with ECIS
- Complete demand and capacity work to further understand bottlenecks and their impact across the system
- A&E Performance meetings organised in addition to regular contractual meetings.
- New induction programme for new nursing staff in A&E.
- Analyse capacity and demand patterns & roster staff at peak demand
- Increase medical staffing over evenings and weekends in line with high levels of breaches at these times.

Out of Hospital

- Ivy Court Medical Practice (Ashford Rural) operating 7 day a week Primary Care
- "Encompass" implemented 7 day working
- Reviewed structure of Integrated Discharge Team and assign new KPIs (5 discharges per site per day)
- Implemented Discharge To assess pathways across all acute sites
- Introduction of new CQUIN to encourage ambulances to access LRU to avoid conveyances to Hospital
- Introduction of Paramedic Practitioner services to reduce Ambulance conveyances to Hospital in Whitstable (Seen 5% reduction in managed conveyance rate)
- Implemented real time escalation, imbedding best practice into front line response & tracking actions in real time

Historically, across the NHS, the winter period brings additional pressure on the urgent care system. In order to plan for this, the health economy as a whole (including main health providers plus KCC Social Care) developed the Winter Escalation Plan. During the course of the 2015/16 winter, a number of risks have been identified including an increased number of delayed discharges and ambulance handover, impact of Operation Stack and adverse weather (specifically flooding), increased length of stay and a higher acuity of certain cohorts of patients.

To address this, a number of steps have been taking and mitigating actions put in place. This includes a focused system response to reduce the number of medically fit patients in acute hospitals, improved flexibility in existing community and social care bed capacity, further reductions in Ambulance patient conveyances through expansion of paramedic practitioner pilot, increased provision of support to elderly in homes, improved response and capacity for mental health services (specifically Liaison Psychiatry) and the realisation of the full potential of the Discharge to Assess pilots to improve patient flow.

Achieving Constitution Standards

Referral to Treatment (RTT) Standards

To Be Completed

Achieving Constitution Standards

Cancer Standards

To Be Completed

Achieving Constitution Standards

Mental Health Standards

To Be Completed

DRAFT

Version 1.5

NHS Ashford Clinical Commissioning Group

NHS Canterbury & Coastal Clinical Commissioning Group

Transforming Care

People with Learning Disabilities

As part of both CCG's response to Transforming Care, the local in-patient assessment and treatment unit for people with learning disability (The Birling Centre) was decommissioned in 2014, closing 10 in-patient beds which served Kent and Medway health economy. The budget for the Birling Centre was fully reinvested in enhanced community learning disability (LD) services. The enhanced team now allows for more preventative interventions to be planned and delivered. Work is ongoing to embed the new care pathway and new ways of working in the community which will be supported through Integrated LD Commissioning arrangements between the CCG and KCC from April 2016. The CCG has also entered into formal joint commissioning with KCC for children and young people in the 0-25 age group.

The care pathway for people with LD now includes a new Complex Care Response pathway that sets out how community practitioners from our 3 statutory sector providers; KMPT, KCC and KCHFT, come together to work intensively with an individual whose community support arrangements are at risk of breaking down and who is at risk of being admitted to hospital as a result. The aim of the Complex Care Response part of the LD care pathway is to reduce the numbers of people with LD or ASC being admitted to in-patient services. Since these new elements of LD services have been commissioned in January 2015, the CCG has not been required to admit any adults with LD to specialist in-patient units such as the former Birling Centre.

Through the integrated commissioning arrangements, we work in partnership with the other CCGs in Kent and KCC, forming a Kent Transforming Care Partnership. Together with our partners we submitted the first draft of our Transforming Care Plan on 8th February. Our plans have identified some gaps in our provision which we plan to address. These include:

- the provision of safe accommodation in the community as an additional measure to prevent inappropriate hospital admission. This will provide an additional resource to the enhanced community teams working with people at risk of admission.
- forensic outreach services. We are working with NHS England Specialised Commissioning Team on the development of a forensic outreach service which would enable people who may present a risk to themselves or the community to be safely discharged and also work with people who may be at risk of offending to prevent admission.

We are also applying to the national £30 million fund to help develop further the support for people with Autism who may challenge and / or have additional mental health problems through implementation of our new neurodevelopmental delay pathway.
Our plan estimates that we will need access to 48 beds across Kent to meet the needs of people with LD / Autism who present challenges or who may have additional mental health problems. With the measures above and the continued work to discharge people we will be on track with our partners to reduce our reliance on specialist in-patient beds.

The CCG continues to work in collaboration with commissioning and provider partners, including Specialised Commissioning, to ensure that we have an appropriate range of community services and accommodation for people with LD or ASC.

Local procedures are in place to ensure that national Care and Treatment Review Policy and Guidance is implemented for every patient who is referred for in-patient treatment. We are currently reviewing Tier 4 CAMHS admission procedures to ensure that CTRs are extended to this cohort during the early part of 2016/17.

Transforming Care

Children, Young People and Maternity

NHS Ashford Clinical Commissioning Group
NHS Canterbury & Coastal Clinical Commissioning Group

To Be Completed

DRAFT
Version 1.5

Quality Strategy
Improvements in Quality

Overall responsibility for quality lies with the 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.

Both CCGs 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

Provider Specific – East Kent Hospitals NHS Foundation Trust

The CQC inspection report highlighted quality issues throughout the Trust. Governance, leadership, culture and strategy are all themes that affect patient safety and the quality of care. Recovery Action Plans are in place for A&E, Cancer and RTT and work is being undertaken to ensure these raise the quality of patient care and safety as well as improving performance. Further high level action plans are in place across the trust for areas including End of Life care, outpatients, diagnostics and safeguarding.

Maternity services will be evaluated following the national review and redesigned to deliver safe and effective care, reducing maternal and neonatal morbidity and mortality.

Provider Specific – Kent Community Health NHS Foundation Trust

Service redesign is moving at pace to provide integrated teams - patient experience and quality of care will be embedded in these new pathways

Services are being reviewed during contract negotiations with workforce and productivity being closely monitored to ensure safe care is delivered

Patients safety incident reporting will continue to be monitored;
Priority needs to be given to develop skilled clinical leadership to deliver focused care based on improving patients health outcomes

Provider Specific – Kent and Medway Partnership Trust

Monitor CQC action plan and identify where mitigation needs to be taken to reduce avoidable deaths and patient harm

Support provider to develop robust serious Incident process including reporting, investigating and learning from serious incidents.

Quality Strategy

Delivering Harm Free Care

Safeguarding

Maintaining a focus on safeguarding for the most vulnerable groups is a priority concern we 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
- 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

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 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.

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.

The Financial Challenge

Achieving Financial Balance

The CCG's have received their predicted growth in allocations for the next five years. Population growth and an ageing population in NHS Ashford and NHS Canterbury CCG are expected to put considerable pressure on the finance resource.

Clinical Leadership of Financial Planning

The Both CCG's have implemented the Commissioning for Value (Right Care) process for decision making and performance management. In addition the CCGs have escalated to oversight of projects and delivery with executive steering oversight, lead by AO on a two weekly basis. Both CCG's to date are delivering over 80% of the QIPP / CfV savings plans, however as the plan for Ashford is proportionately greater than Canterbury, almost twice, this non delivery in Ashford is a significant issue that the CCG is addressing through strengthening controls, driving delayed programmes and ensuring that all funds due to the CCG are recovered.

NHS Ashford CCG

The plan is to deliver a 1% surplus in 2016/17 and thereafter. The challenge will be greater in 2016/17 with the current forecast for 2015/16 predicted to be break even, therefore having no prior year surplus to invest to support the position. The plan is also to increase the contingency from 0.5% to 1.5% to cover risks of overspending in programme budgets. These planning assumptions and the provider pressures in the system for 2016/17 and thereafter will mean that delivery of transformational change programmes becomes a priority for the CCG.

NHS Canterbury CCG

The plan is to deliver a 1% surplus in 2016/17 and thereafter. NHS Canterbury CCG will have the benefit of the prior year surplus to support the position. The plan is also to increase contingency from 0.5% to 1.5% contingency to cover risks of overspending in programme budgets. These planning assumptions and the provider pressures in the system for 2016/17 and thereafter will mean that delivery of transformational change programmes becomes a priority for the CCG.

QIPP

The scale of the QIPP to be delivered is significant. Transformational schemes that commenced in 2015/16 will be extended and reinforced in 2016/17 such as Orthopaedics and those that have been planned over the last financial year are planned to be phased in over 2016/17.

2016/17 Commissioning Intentions

Commissioning for Value

Our priorities for 2016/17 come from a number of different approaches. They are drawn from our original five year plan, pressures identified through ongoing performance managements and through a newer approach known as "Commissioning for Value".

We took this approach following a review and reflection upon previous annual plans, from this we identified that we attempted too much change and only fully achieved about 1/3 of our intended priorities. We therefore needed to focus our efforts on areas that would generate best outcome clinically and financially and to streamline our approach to commissioning by reducing the number of priorities and revamping our internal monitoring regime.

In November 2014 we therefore engaged the national led for NHS Right Care, Professor Matthew Cripps, and by end of January 2015 we had;

- Reviewed the data using various sources, Pathways on a Page, Atlas of Variation etc., to identify key opportunities for improvement
- Held a workshop, lead by clinicians, to formulate our local decision tree which would give us a consistent approach to prioritising projects
- Undertook a series of engagement approaches through presentations and discussions with staff, Governing Bodies, Membership and key providers who endorsed the approach
- Held a joint CCG "clinician to clinician event", involving both GPs and Consultants to launch optimal pathway design based on key priorities identified through the process
- Completely redesigned our business and governance processes, including the creation of the "Health Reform Delivery Panel" chaired by Dr Navin Kumta, creating a single filter for decision making and allowing for a single route for ***all*** proposed projects to be considered
- Changed culture to one of evidence based decision making, using evidence from national and internationally recognised sources – such as Cochrane – to assess the efficacy of proposed models of care
- Produced a revised set of templates for commissioners and partners to compile Initial Viability Assessments, Outline Business Cases and Post-Implementation Reviews to bring to the panel

2016/17 Commissioning Intentions

Elective Care

Project	Summary	Estimated Savings
Musculoskeletal (MSK) Triage	To triage all GP referrals for musculoskeletal (MSK) conditions to Trauma and Orthopaedics (T&O) at EKHUFT. This will be provided by Ashford Provider Group utilising GPs with expertise in MSK in Ashford, and by identified Community Network-based providers in Canterbury; and will complement the use of Referral and Treatment Criteria (RaTC) within the Demand Management.	£ 3,880,000
Musculoskeletal (MSK) – Spinal Injections	To introduce a new clinical pathway for patients with chronic back pain to ensure they are managed in a supportive way using techniques for managing pain on a day to day basis. This will maximise care in primary and community care through implementation of specialised therapy and counselling support thereby reducing referrals to secondary care. Patients currently on the T&O waiting list for spinal pain injections will be reviewed to see if according to the new pathway they could now be treated in primary and community care.	£ 800,000
Further Musculoskeletal (MSK) Pathway Development	The focus for 2016/17 will be: · Finish implementing the Back Pain Pathway (Spinal Injections – see above) · Fully implement MSK triage (See above) · Addressing variation in referrals for direct access MRI · Working with clinical and management teams in EKHUFT to develop service development options, in addition to addressing referral variation, for addressing the variation in surgical intervention rates, readmission rates and complications for Hip replacements (including revisions), knee replacements (including revisions) and arthroscopies. · This development will be phased over the course of the year. The first 6 months will focus on projects already underway and new projects will be developed to begin to take effect in the second half of the year	£ -
Wet Age-Related Macular Degeneration	Procurement of a new community service for patients suffering with eye conditions which fall into the category of Macular oedema and specifically Wet Age-related Macular Degeneration. The current pathway is provided solely in acute services but there is potential to repatriate patients back to primary/community care for much of the pathway especially once diagnosis has been established. At the same time this will give a financial benefit and ease capacity issues in acute services to offset the increasing demand for new drugs and new treatments being recommended by NICE	£ 200,000
Ophthalmology Triage	Northgate Medical Practice has provided an ophthalmology service for many years lead by Dr Andy Charley since the retirement of Dr Simon Ellis in March 2013. The service currently accepts all internal non urgent practice referrals from clinicians working within NMP and direct Optometric referrals from community Optometrists via GOS18's, treating those which can be within the teams competence and referring those on that need to be.	£ -
Dermatology Advice and Guidance	To pilot an integrated intermediate tele-dermatology triage service for dermatology referrals, excluding Cancer 2 week wait (2ww) referrals. To ensure that patients are assessed quickly and have access to the correct treatment based within a community setting, thereby ensuring that secondary care has the capacity to manage cases requiring surgery or specialist intervention as a result of reduced referrals. A community service model will be embedded across Ashford and Canterbury CCGs to ensure that all providers are delivering one-stop pathways	£ 1,262,481

2016/17 Commissioning Intentions

Urgent Care and Long Term Conditions

Project	Summary	Estimated Savings
Discharge to Assess	○ **Pathway 1** - discharge home with 'wrap around' community teams to provide assessment to specify on-going care needs over a 72hr period. The focus on home first and reduce the number of patients that are transferred to Health & Social Care Village (H&SCV) beds for rehabilitation. ○ **Pathway 2** – discharge to assess where home is not an option, to bed-based facilities (community Hospitals / KCC step down beds) for ongoing assessment and rehabilitation for a period of 2- 6 weeks**.** Patients who require 24hr nursing care, daily medical review and rehabilitation to support discharge home, within 21 days of admission. ○ **Pathway 3** – Discharge to assess to nursing home for patients who require assessment of their long term care needs outside an acute hospital environment, providing a period of assessment during which an appropriate placement can be sourced. Assessment and placement are completed within 6 weeks by dedicated CHC nurses and social worker.	£ 2,000,000
Over 75s Admissions	To support the reduction in urgent care admissions for patients over 75 through the implementation of a number of different schemes: • Unplanned Admissions DES • End of Life • Care Homes • Frailty CQUIN • Community Geriatrician Project • Practice-based over 75s Scheme • Integrated Care Team Review	£ -
Age UK Living Well Programme	This is a national project which looks at reducing reliance upon health and social care through promotion of wellbeing. The project looks at taking cohort of patients in Ashford Rural, Faversham and Herne Bay over 65 years, with 2 or more long term conditions, who have had 1 unplanned hospital admission in the last 12 months and a high likelihood of another; and providing a period of intensive support to them through Living Well Coordinators to help them achieve identified health and wellbeing goals.	£ 920,380
Canterbury Transitional Beds	Six-month pilot starting in February 2016 for 3 additional transitional beds to prevent hospital admissions for patients requiring short-term support within the Canterbury community whilst remaining under the care of their registered GP. The pilot will focus on two conditions: Urinary tract infection, and lobar pneumonia. Three beds will be purchased to give capacity for 59 patients, based on an average length of stay of 7 days and 75% occupancy rates	£ 182,516
Anticoagulation Services	NHS England has confirmed they will be decommissioning the pharmacy-delivered anticoagulation monitoring services from March 2016. This provides the CCG with an opportunity to review anti-coagulation services provided by primary care in parallel, with a view for all provision to sit under one service specification underpinned by robust contractual arrangements that are managed by the CCG. Current contracting arrangements focus on activity rather than patient outcomes. This will be addressed in the service review. The review will be undertaken in two phases: **Phase one:** procure monitoring services only - excludes initiation of anti-coagulation treatment. **Phase two:** Review and procurement of initiation of anti-coagulation treatment. This will include a Post Implementation Review (PIR) of the Ashford initiation service. The draft business case is proposing a single service where, as a minimum, all providers • offer the entire service in accordance with the service specification • are able to offer home visits as a compulsory element against the criteria defined in the service specification, rather than optional as current • will monitor the patients according to the service specification • can see patients from all practices • will be expected to use INR Star • will be expected to prescribe warfarin or acencoumarol • conduct training in accordance with the service specification	£ -

Contracted Activity 2016/17

NHS Canterbury and Coastal CCG

Activity Line	15/16 Forecast Outturn	16/17 Plan	Growth Assumption
Total Referrals (GP and Other)	75663	75849	0.2%
Consultant led Total 1st Outpatient attendances	63706	62989	-1.1%
Consultant led Follow up outpatient attendances	119532	119109	-0.4%
Total Elective admissions (spells)	30270	30342	0.2%
Total Non-elective admissions (spells)	25628	25655	0.1%
Total A&E attendances	57447	57424	0.0%
Total Endoscopy tests	5643	5744	1.8%
Total Diagnostic tests (excluding Endoscopy)	74838	76099	1.7%
Total Cancer 2WW referrals	9689	9574	-1.2%
Total Cancer 62 day waits	622	624	0.3%